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ABSTRACT

This newsletter theme issue focuses on the training of practitioners to work with infants, toddlers, and their families with emphasis on the activities of the TASK (Training Approaches for Skills and Knowledge) Project of the National Center for Clinical Infant Programs. The TASK project addresses the concerns of four "stakeholder" groups: parents; educators; professional organizations and practitioners; and policymakers and administrators. The following articles are included: "Educating Allies; Issues and Recommendations in the Training of Practitioners To Work with Infants, Toddlers and Their Families" (Emily Schrag Fenichel and Linda Eggbeer); "Individualizing Training for Early Intervention Practitioners" (Carole Brown and Eva Thorp); "Teaching and Learning: My First Year as an Advisor at Wheelock College" (Jill Bohlin); "A Developmental/Relationship In-Service Training Model for Public Health Nurses Serving Multirisk Infants and Families" (Serena Wieder et al.); "Mediating Successful Parenting: Guidelines for Practitioners" (Serena Wieder); and "Family Administrated Neonatal Activities: An Innovative Component of Family-Centered Care" (Ida Anne Cardone and Linda Gilkerson). Also provided is a list of 29 new and ongoing training initiatives for practitioners working with infants, toddlers, and their families. Information provided includes some or all of the following: the sponsoring institution; a program description; a contact person; eligibility requirements; and stipends available. (DB)

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Educating Allies: Issues and Recommendations in the Training of Practitioners To Work with Infants, Toddlers and Their Families

by
Emily Schrag Fenichel and Linda Eggbeer
National Center for Clinical Infant Programs

The outcome of both traditional and innovative efforts to support the development of infants, toddlers and their parents depends in large part on the effectiveness of working alliances between families and the people who provide them with health care, education, social services and emotional support. The effectiveness of these alliances, in turn, depends largely on the training of each of the "allies" involved. Such a statement raises difficult questions:

- What knowledge, skills and attitudes do practitioners need to help foster the development of children and families in the earliest years of life?
- What underlying concepts and insights about very young children and their families can form the foundation for a language common to parents, researchers, teachers, and practitioners in the many disciplines concerned with infancy?
- What kinds of training experiences seem likely to enable students and beginning practitioners to achieve competence in collaborating with families and colleagues from diverse backgrounds on behalf of infants and toddlers?

It was to explore questions such as these that the TASK (Training Approaches for Skills and Knowledge) Project of the National Center for Clinical Infant Programs was funded in late 1987. Guided by the expertise and insight of nine professionals and parents

D. MICHAEL HOSTETLER

with many years of training and experience, the TASK project has sought to address the concerns of four groups with a major stake in training personnel for work with infants, toddlers and their families. These "stakeholder" groups include:

- Parents
- Educators
- Professional organizations and practitioners; and
- Policymakers and administrators.

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Because each of these groups has a unique perspective but also needs to collaborate on many issues related to training, the TASK project aims to offer a forum for discussion of common concerns among the stakeholders. The activities of the project are designed to provide a framework for thinking about key issues that will be meaningful to all the groups involved, and to develop a common language for dialogue.

Since early in 1988, TASK project staff and advisors have created a nationwide communications network of approximately one thousand individuals who are engaged in some aspect of the training of infant/family practitioners. In addition, the project has been involved formally or informally with a number of national and state personnel preparation initiatives related to the implementation of PL 99-457. TASK staff and advisors are also developing a series of publications to assist each stakeholder group in addressing training issues of particular concern.

Several major themes have emerged from the work of the TASK project and are reflected in the specific recommendations that the project is making to the field.

1. Specialized knowledge and skills, as well as close collaboration between parents and service providers from a variety of disciplines, are required to support the development of children from birth to three and their families. Therefore, all training programs for infant/family practitioners, whether they are at the pre-service, in-service, or professional development level, must prepare individuals to be both specialists and generalists. They must enable practitioners to adapt the knowledge and skills of their own discipline to the specific requirements of work with infants, toddlers and their families. At the same time, training experiences must help practitioners acquire enough generic knowledge and human services skills to function in the larger context of child, family and community in which development occurs.

2. In thinking about the competence of infant/family practitioners, it is important to recognize a continuum of competence. The requirements of practice vary widely, and individuals with many different levels and types of training, experience and talent can do well given appropriate roles and support. It is also important to consider the overall competence of the staff as a whole in evaluating the effectiveness of a service program or service system.

3. Training issues belong high on the agendas of all advocates for very young children and families. The success of health, education, social services and comprehensive programs designed to support and strengthen infants, toddlers and their parents depends in large part on the quality of training available for professional, paraprofessional and volunteer personnel. At the same time, advocates for better training must recognize the vital importance of higher salaries and improved working conditions for practitioners as well as the need for universal access to high quality services for children and families.

This article, largely excerpted from TASK project working drafts, first discusses the issue of defining competence in infant/family personnel and programs. It next examines four key elements in pre-service and in-service training and in professional development efforts that seem likely to foster competence in working with infants, toddlers and their families. Finally, a set

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of ten recommendations is proposed that could form the foundation for an action agenda for all groups concerned with the training of infant/family practitioners.

Defining competence in infant/family personnel and programs

Individual competence

Competence can be defined as the ability to do the right thing, at the right time, for the right reasons. Competence involves the capacity to analyze a situation, consider alternative approaches, select and skillfully apply the best observation or intervention techniques, evaluate the outcome, and explain each step of the process. Competence generally requires a combination of knowledge, skills and experience. Competence for work with infants and families cannot be inferred from the completion of academic coursework alone; it must be demonstrated.

Because appropriate demands on an infant/family practitioner may vary so widely, it is important to recognize a continuum of competence. Whatever the discipline involved, the professional tends to move from an approach that follows learned protocols to a more independent practice, guided by the integration of experiences, increased knowledge, and sharpened observation.

A new graduate of any training program, even one with infant/family content and supervised practicum experiences, begins practice on the first rung of the competency ladder and climbs from there. She gradually builds a repertoire of behavioral skills that reflect the principles and basic beliefs she holds about those with whom she works and about herself as a professional. She learns to deal with increasingly complex demands of daily practice. As she masters skills and deepens understanding, she begins to teach others as she continues to explore new aspects of the field.

This growth is not a given, however. Some practitioners seem unable to move beyond the novice stage; others seem to move very rapidly to positions of leadership; others experience some form of "burn-out" and become less competent over time.

To evaluate the competence of an infant/family practitioner, then, one would need to understand both the particular demands of the job and the training and experiences that the practitioner has brought to the task.

Certifying the competence of the individual practitioner

To certify the competence of the child care provider, the early childhood special educator, the neonatologist, or any other infant/family practitioner, one would need to describe exactly what kinds of behavior are to be expected from a practitioner judged to be competent in a particular area. One would need either to be confident that performance on an examination reflected on-the-job competence or to observe competent behavior in practice.

Editor's note

As editors of *Zero to Three*, which, we are pleased to note, is frequently used as a training resource for infant/family practitioners, and as members of the TASK Project of the National Center for Clinical Infant Programs, we are very much concerned with training issues. But to be concerned about the training of people who work with infants, toddlers, and their families and even to do such training is not the same as writing well about the subject. Fortunately, the contributors to this issue of *Zero to Three* have been able both to explore new territory in the training of infant/family practitioners and to chart an appealing course for others to follow.

Carole Brown and Eva Thorpe let us know how it feels to supervise very different kinds of students as they encounter challenging infants and families. Jill Bohlin tells us what happens—and what it feels like—when a professional training program hires a parent advisor. Serena Wieder, Robert Drachman, and Tippie DeLeo describe a remarkable collaboration among front-line Community Health Nurses, Health Department administrators, and a trainer/clinician. This resulted in a sustained in-service training program designed to help practitioners meet the specific challenges of working with multirisk families of infants and toddlers. Ida Cardone and Linda Gilkerson report on their efforts to integrate insights from behavioral pediatrics, psychotherapy and the family resource movement, creating a new component of parent education, Family Administered Neonatal Activities. Finally, information on pre-service and continuing education programs, submitted by more than 30 institutions in response to the invitation in our June issue, reveals a wealth of opportunities to learn about working with infants, toddlers and their families.

The training efforts described in this issue of *Zero to Three* are pioneering ones. As the recommendations of the TASK Project suggest, we have far to go before we can feel confident that well-trained professionals, paraprofessionals and volunteers are available to support the development of all children and families in the earliest years of life. Meanwhile, we salute the explorers and resolve to follow, or to chart our own courses, toward common goals.

For example, the Council for Early Childhood Professional Recognition, which awards the Child Development Associate (CDA) credential to infant/toddler caregivers in child care programs, evaluates a candidate's performance in 13 competency areas. Each competency area is divided into a number of specific behaviors that can be observed in actual interaction

between a caregiver and infants, toddlers and their families. When taken together, these observed behaviors indicate the presence or absence of that competency. The behavior of each candidate for the CDA is observed in these areas on three occasions by a qualified advisor. A portfolio of written material is also reviewed before the credential is awarded.

As part of the implementation of PL 99-457, the Education for the Handicapped Act Amendments of 1986, state agencies are working to recognize or develop certification requirements for a variety of professionals and paraprofessionals who work in early intervention programs. Few professions named in the legislation, however, have even delineated the infant/family content in their discipline, let alone suggested mechanisms for certifying competence that are based on observation of actual practice.

A consensus is emerging across a number of disciplines that the following general areas of competence are important for all practitioners working with both typically and atypically developing infants, toddlers and their families. These broad areas offer a framework within which to place the specific behavioral criteria needed to certify the competence of practitioners in a particular discipline or of workers with particular responsibilities. In addition, these areas can provide a general guide to planning training experiences for students and practitioners in the field. These areas include:

- **Mastery of relevant conceptual and factual knoweldge;**
- **Adaptation of the knowledge, skills, and service approaches of a given profession to the particular circumstances and needs of children from birth to three and their families;**
- **Use of self-knowledge in collaboration with families, colleagues and others to support the development of infants and toddlers; and**
- **Continuing growth through study, research and reflection.**

It is the integration of knowledge and skills across these areas that is the hallmark of the competent practitioner. She must be able to apply knowledge and skills to the circumstances of individual infants and parents; be able to explain why she has chosen certain approaches; and be sensitive to the impact of her words and actions on the relationship with both child and parent. She must use her experiences, successful and unsuccessful, as material for further learning.

"Program competence"

As credentials are developed for individual practitioners, it will be important for administrators, policymakers, and parents also to think about competence in relation to service programs and to service delivery systems. What combination of knowledge, skills and experience will be needed by the staff as a whole in a program that has decided to address particular areas of concern in a specific population of infants and parents? If personnel with desired competencies cannot be recruited, what services or supervision could be provided by consultants? What referrals to other programs would be necessary? What on-the-job training could be expected to give inadequately prepared staff the skills they need? How are scarce skills to be deployed? Are caseloads and reimbursement policies set in a way that encourages programs to take the time to share expertise?

Again, the focus must be on demonstrated competence rather than on paper credentials. Thus, a social worker familiar with principles of community organization who is new to an early intervention program iis likely to know less about effective networking on behalf of the program's participant families than the therapists who have worked in the program for several years. With time, however, the social worker's specialized skills in community organization may bring the program to a position of leadership with regard to interagency coordination of care. Overall competence in an infant/family service program is likely to come,

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then, from a blend of more experienced and less experienced staff whose conceptual, technical and practical expertise complement and enrich each other.

A skilled staff is not enough to assure program competence, however. Administrative policies are key in determining the quality of services offered to infants and their families. Salary structures and extremely difficult working conditions in the field prevent staff from reaching, maintaining or using needed skills. Thus poorly paying child care programs may lose their entire staff in the course of a year, with demoralized caregivers frequently leaving the field altogether. Early intervention professionals, whatever their discipline or work setting, find it difficult to maintain a commitment to a work setting that imposes large caseloads and fails to offer adequate supervision or support.

Members of the TASK Project believe that it will take significant effort and time for each discipline concerned with infants, toddlers and their families to articulate specific competence criteria for individual infant/family practitioners within the general areas described above. Describing the "competent" service program for young children and families is an equally formidable challenge.

Training experiences to foster competence

The development of professional competence involves recognition of one's own powerful emotions as well as the acquisition of scientific knowledge and therapeutic skill. Both the process and content of training experiences are important.

Members of the TASK Project have identified four training elements that are likely to help individuals become competent infant/family practitioners. These elements can be found in pre-service training, in-service training, and in professional development initiatives.

1. The knowledge base that any infant/family practitioner is required to master should include a conceptual framework common to all infant/family disciplines.

It is the conviction of members of the TASK Project that key concepts can be identified that underlie all sound practice with children and families in the first three years of life. These concepts have emerged as powerful integrators of information across fields of inquiry and as general guides for practice useful to many disciplines. They help to organize what is known about infants and families and to suggest what is yet to be discovered or understood.

Key concepts that form a basic framework for infant/family practitioners include: 1) endowment, maturation and individual differences in the first three years of life; 2) the power of human relationships; 3) transactions between the child and the environment; 4) parenthood as a developmental process; 5) developmental processes and their interrelationship; 6) risk, coping, adaptation and mastery; and 7) the helping relationship.

An example of building on this common knowledge base at the level of pre-service training might be the inclusion of materials on the emotional relationship between parent and child in the maternal and child health curriculum at a school of public health. At the in-service level, one might see early intervention staff being trained in assessing and encouraging coping skills in infants with disabilities with particular attention being paid to their emotional overtones in both infant and parent. At a professional development conference for experienced practitioners from a range of disciplines, one might find a presentation on the early growth of language and communication in the context of emotional development.

2. Contact with infants and families is an essential element of training for infant/family practitioners.

Within pre-service training, contact may involve such diverse activities as systematically observing parents and infants, providing respite care for a family with a toddler with disabilities, or completing a supervised practicum involving substantial program responsibility. At the in-service level, contact is likely to come through supervised application of principles and techniques presented in lectures or workshops. In training for professional development, the practitioner is likely to need contact with infants, families and/or other adults as she assumes a new role. For example, a parent who has been involved in one-to-one parent support may team with an experienced advocate to learn how to function effectively in local or state policymaking bodies.

3. Individual supervision offers a training experience that blends process and content.

The supervisor helps the trainee review the information she has gathered and the choices she has made in practice. Why, for example, was one intervention chosen over another? Questions and comments may direct the trainee to new lines of inquiry or alternative intervention strategies. The supervisory relationship also affords the trainee a safe place to examine a range of feelings aroused by infants, families and colleagues, and to formulate professional responses.

At the pre-service level, this element may actually be more like mentorship, as a teacher who is passionately involved in work with infants, toddlers and families motivates a student to specialize in this area. At the in-service level, supervision may be the single most important element of training. It should never be simply a monitoring process, but should constitute an ongoing relationship in which the agenda is all aspects of the professional use of self. At the level of professional development, supervision can be thought of as consultation, with peers or professionals with specialized expertise.

4. Seeking and offering collegial support is a hallmark of infant/family practice that should also be part of training.

During pre-service training, group academic projects, informal contacts, and student affiliation with infant and family-related professional and advocacy organizations can add to a feeling of connectedness with others who are working toward common ends. Early interdisciplinary experiences can be espcially useful. In practice settings, effort is required by administrators and front-line service providers alike to create an atmosphere of openness, collaboration, and support for the expression of negative as well as positive feelings. At the level of professional development, collegial support serves to combat the isolation that is often an occupational hazard of infant/family work, while at the same time providing opportunities for expanding expertise. National, regional and local professional and advocacy organizations offer opportunities to receive and share information in a supportive context. Participation in committees or special projects expands collaborative possibilities.

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Allied Action: Recommendations of the TASK Project

A consideration of the four elements essential to the training of infant/family practitioners and of current issues in pre-service, in-service, and professional development suggests a variety of strategies to enrich the education of practitioners who work with infants, toddlers and their families. In order to focus the attention and energy of parents, professionals, educators and policymakers, members of the TASK Project have developed a list of ten recommendations.

Recommendations are grouped under the general headings of pre-service, in-service and professional development. However, the fact that financing of training, for example, is listed as a pro-service issue does not mean that funding for in-service training is

adequate. Each recommendation can involve collaboration among several or all of the four "stakeholder" groups, with roles varying depending on the goal to be achieved.

Pre-service training

1. The financing of pre-service training for practitioners planning to work with infants, toddlers and their families deserves a thorough review. There are many questions to be addressed such as how to use stipends as incentives to students to become infant/family practitioners; how to use funding mechanisms to provide personnel for underserved areas and populations; ways to allocate funds to support both ongoing programs and innovative training initiatives; and what role community colleges and vocational programs should play in training personnel.

2. Involvement with families and service programs in the community should be integrated into pre-service training. Many models of supervised practicum experiences, volunteer projects, and the use of parents and practitioners from the community as teachers and advisors are available for consideration and replication.

3. Specific efforts should be made to improve the quality of infant/family content that is offered at the pre-service level. A resource bank of print and audiovisual materials (with particular emphasis on detailed case reports) and curriculum guides, for example, would give instructors access to the products of successful demonstration training projects. "Training of trainers" seminars would expose educators to state of the art research and clinical information and at the same time allow them to share effective teaching methods.

In-service training

4. Supervision in infant/family programs be recognized as a major in-service training mechanism that both improves program effectiveness and responds to the training needs of individual practitioners. Adequacy of supervision should be recognized as an indicator of program quality by program participants, potential employees, and funders. Training in supervisory skills should be available in the community under the auspices of professional and/or educational institutions.

5. The content and format of in-service training should reflect emerging trends in practice with infants, toddlers and their families. The redefinition of parent/professional relationships, for example, is creating fundamental and far-reaching changes in many areas of practice. The parent perspective has become essential to in-service training. Similarly, serving culturally diverse families with infants and toddlers and collaborating with multiple disciplines and agencies have become critical in-service training issues.

6. Local, state and/or regional mechanisms should be created to help coordinate and finance in-service training, with particular emphasis on approaches that offer opportunities for consultation and follow-up as new skills are practiced. Coordinated in-service efforts seem particularly timely as major initiatives such as the implementation of PL 99-457 get underway. At the same time, the unique characteristics and needs of individual programs should be respected. "Packaged" in-service training programs that are not individualized are likely to be of limited lasting value.

Professional development

7. Appropriate licensure, certification or endorsement standards should be established by individual professional disciplines for personnel working with infants, toddlers and their families. Despite understandable pressures for the rapid development of personnel standards to meet staffing needs, each discipline should resist temporary, and perhaps inadequate, short-term solutions. Instead, they should invest the time and effort necessary to establish appropriate guidelines for certification and licensure that are likely to enhance collaboration and policymaking over the long-term.

8. Combating the isolation that is an occupational hazard of practice with infants, toddlers and their families should be a top priority for professional development initiatives. These may include specific outreach strategies to practitioners in remote geographic locations or otherwise isolated work settings, as well as efforts to bring practitioners from different disciplines and settings together through conferences, courses, and print and electronic communication.

9. Training experiences should be developed that systematically prepare selected practitioners to assume leadership roles in supervision, administration, policy development, advocacy and research. Ongoing mechanisms for peer support and feedback as new roles are assumed should also be provided, either in the community or through larger networks that take advantage of telephone and electronic communication.

10. Incentives to attract and retain infant/family practitioners in the field must be recognized as critical to the success of work that depends on enduring human relationships. Parents, educators, policymakers and practitioners must jointly advocate for salaries that are sufficient to attract beginning practitioners to work with infants, toddlers and families and that increase to allow experienced workers to provide for their own families. Opportunities to combine work and family roles in different ways at different life stages warrant further study and replication, as do administrative policies concerning caseload size, negotiation of job responsibilities and staff morale.

Next steps

Members of the TASK Project believe that these ten priorities constitute an agenda for training that addresses concerns common to parents, professionals, educators and policymakers. We believe that it is time to commit significant national resources to achieve the far-reaching improvements outlined here. At the same time, we recognize that long journeys begin with small steps. Modest initiatives, well-planned and executed, can often provide the confidence and experience of succes that make larger endeavors conceivable.

Readers of this article are encouraged to write or call Linda Eggbeer or Emily Fenichel at the National Center for Clinical Infant Programs with ideas and information to share concerning the training of infant/family practitioners or with questions about how to become involved in the TASK Project. There is much to be done.

Individualizing Training for Early Intervention Practitioners

by
Carole W. Brown, U.S. Department of Education
and Eva K. Thorp, George Mason University

Individuals pursuing pre-service or in-service training in early intervention services come to the training experience with a number of strengths. Not the least among these strengths is the fact that their enrollment in a training program is a sign of their willingness to learn and change. However, change does not always come easily. For a variety of reasons, students may be unprepared to apply family-centered principles in their work with families. Often these individuals come from previous training programs that have prepared them to work with children, but not the families of these children. Their sole exposure to a family focus may have been reading about "the stages of grief." They may or may not have had personal experiences that allow them to be introspective and demonstrate self-knowledge. They may or may not have had experiences which would enable them to understand the daily routine and challenge of parenthood. They may or may not have had direct positive experiences with handicapped individuals in their family or peer group or neighborhood.

The unique blend of skills and personal experiences that each individual brings to training forms the context for supervision. Composite descriptions of some students, whose strengths and vulnerabilities are based on the students we have worked with, in several settings, will be used to illustrate the importance of individualizing educational experiences.

The young student

Alice is a 22-year-old who has recently graduated from an undergraduate training program in special education. She has demonstrated great skill in her coursework and has now decided to proceed to graduate school to obtain advanced training in working with high risk and handicapped infants and their families. Alice is from a rural area and grew up in a supportive, middle-class, two-parent family. She has had a great deal of paid and volunteer experience with children with handicaps. She has, however, had no experience with their parents: she has never done a home visit and is unsure of what she would do on one; she has no knowledge of the social service web which often surrounds families with multiple problems.

The child advocate

Susanne is a thirty-year-old who has been employed for several years as a parent-infant educator. She has an undergraduate degree in child development but feels the need for further training and skills in order to work

Note: Contributions to this article by Carole Brown were made in her private capacity and do not reflect an official position by the Department of Education.

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effectively under PL 99-457 guidelines. She is highly skilled at developing individualized learning plans for the children with whom she works. She has done home-based service delivery and sometimes develops strong friendships with families. She has very strong feelings about helping children with special needs. At the same time, she feels that it is not relevant to attempt to understand the emotional climate of the families with whom she is working. She especially feels that it is completely unnecessary to systematically explore her feelings about her own family and about the families with whom she is working in the process of carrying out her work.

The experienced professional

Lindsey is a 45-year-old speech pathologist who has worked for the past 15 years in a variety of public and private settings. Just recently she has taken a position with an early intervention program. Up to this time she has provided direct therapy to children and has occasionally developed behavioral training programs for parents to carry out with their children. She believes that one of the major barriers to successful outcomes for the children with whom she works is lack of commitment and follow-through on the part of families, particularly those whom she perceives to be "lower functioning".

The families to be served

Each of these students must be prepared to work with a variety of families, including those whose multiple problems typically confound community agencies and providers. Amelia's story is of one such family.

Amelia is 21 and the mother of two children under five years of age, both of whom have some degree of developmental delay. She is married, but her husband has been in and out of their home. Mary, her oldest child, aged 30 months, was in foster care for three months when she was an infant but is now living with

her mother. She often appears unkempt and sad. She almost never vocalizes, although she seems to understand simple requests. Amelia's youngest child is a son, Jack, aged 15 months. He seems quite happy and seems to enjoy a lot of attention from his mother. However, he also vocalizes infrequently, and there is an emerging suspicion of delay. Amelia often appears disinterested in her surroundings, and rarely initiates conversations with other adults or with her children. She receives public assistance, is monitored by social services, and receives home and center-based services for both of her children from a local parent-infant program. Although she typically looks sad and unresponsive, Amelia clearly enjoys any activity that involves music. She has indicated a concern that her daughter is not talking, and she has further indicated that she knows that her daughter seems happier with other people than when she is with Amelia.

What training strategies will be necessary to enable each of the potentially competent professionals above to function in optimally supportive positions vis-a-vis Amelia? What will enable them to identify and support the natural strengths that they bring to the intervention process? What will enable them to explore the meanings that each of her children may have for Amelia? What will enable them to construct intervention environments in which they can support Amelia in her interactions with each of her children? In one student's case there may be a need for a broadened experiential base; in another a need for opportunities for safe self-exploration; in a third, the need for attitude change. What common content combined with what individualized clinical experiences must a training program provide in order to respond to the issues each of these individuals bring to the training process?

The role of a family-centered philosophy

The training materials and media which enable the infant/family practitioner to work effectively with families are by nature eclectic and derived from many disciplines. No one discipline uniquely possesses the knowledge necessary to accomplish this task. Thus, training experiences must integrate in sensible fashion key information from the many disciplines which contribute to parent-infant service delivery. A clearly articulated set of principles, based in theory and acknowledged best practice, about how to facilitate child development and family functioning may be the most appropriate vehicle for integrating this disparate information.

The task for pre-service and in-service training programs is to further explicate a philosophical base that can guide decision-making, intervention, and the development of one's own theories about infants and families. (Odom, 1987).

The provisions of PL 99-457, the 1986 Amendments to the Education of the Handicapped Act, support a philosophical basis for training early intervention services providers. The legislation is based upon assumptions about how families are viewed and what it means for services to be family-centered, about the nature of high risk and handicapped children and how they learn, and about the process of professional interaction across disciplines.

In addition, statements of integrative principles and philosophy to guide family-focused intervention are emerging in the field. Johnson, McGonigel and Kaufmann (1989) have identified conceptual guidelines for best practice in the development of the Individualized Family Service Plan, which is central to the implementation of PL 99-457. Dunst, Trivette, and Deal (1988) have identified intervention principles derived from a family empowerment perspective. McCollum, Thorp and Rowan (1988) have developed integrative philosophy statements to guide training of early intervention specialists.

How might these sets of principles assist our typical students as they begin to interact with families? Alice possesses a firm grounding in intervention with children but has no experience with families. These principles gives her a standard to guide her in new situations. When confronted with an issue in her interaction with families, Alice learns to evaluate her actions for their compatibility with the philosophy. She becomes able to say, "If I believe this to be true about families, what potential strategies are available to me at this juncture? What potential actions would be incompatible with the philosophy?"

In contrast, Lindsey has had "too much" experience. In the absence of a philosophical perspective on the nature and needs of families, she has come to see families as a major barrier to accomplishing her goals for children. Family-centered principles enable her to come back to a more hopeful view of families. They serve as a continuous reminder to look for resourcefulness in families and to listen to what families tell her they want for their children. These become the basis for collaboration.

The role of instructional content

An information base is also required to guide professionals in working more effectively with parents. An understanding of the attachment process and of potential barriers to attachment, for example, will enable Alice, Susanne, and Lindsey alike to examine a parent's behavior in new ways and to develop hypotheses about the nature of the parent's relationships with his or her children. Learning about interaction-focused intervention strategies will enable Alice and Susanne to see that intervention does not require choosing between a focus on only the child or only the parent. They will learn how to extend what they have already learned about structuring child interventions to parent-infant inteventions. Learning about collaborative goal setting and problem solving will enable them to support Amelia in the IFSP process and to assist her in identifying the outcomes she desires from intervention. Further, learning about the role descriptions and disciplinary scope of each of their fellow teammates will enable whichever one of them

is functioning in the case management role to enlist the assistance of the others and will assist all team members in coming to recognize the limits of their own expertise. Finally, when these professionals in training learn about the network of social service agencies in their community, they will acquire a better understanding of the larger context of Amelia's daily life into which they must embed their interventions. It is this latter knowledge that brings a young professional such as Alice to understand that advocacy efforts on behalf of adequate shelter and nutrition for families are appropriately within the scope of early intervention.

The integrative role of individualized clinical experiences

Ultimately it is through systematic and repeated exposure to children and families that professionals come to see themselves as competent infant/family practitioners. It is in these real-life, conflict-ridden situations that students acquire the strategic knowledge of decision making and problem solving necessary in early intervention (Bailey, 1989). It is in these practice settings where students acquire the clinical skills of really listening to all the actors in the family, including the voiceless ones; of generating hypotheses about behavior; and of responding thoughtfully and respectfully (Trout, 1988).

Field experiences should ensure students access to a diversity of families, to a richness of cultural backgrounds, and to a broad range of child and family needs. Such experiences may be acquired at the preservice level through a practicum, or at the in-service level through the implementation of systematic supervised case review and problem solving with experienced professionals. One of the best ways to acquire this knowledge is through exposure to experienced parents of children with special needs in the classroom or through personal interaction.

The supervision process

The work of the clinical supervisor is central to the learning process in the practicum, where students are being prepared for a task which is ultimately interpersonal in nature. Through the relationship she establishes with the student, the supervisor models and calls attention to key aspects of this task. Each professional-in-training will require different strategies of the supervisor, as the supervisor must keep in mind two questions. First, what will it take for this individual to integrate her understanding of infants and families and to apply a family-focused approach to planning and intervention? Second, and perhaps more importantly, what will it take to enable this student to sufficiently explore her own family experience in order to experience empathy for the most difficult of families, thus becoming able to work collaboratively with them? The supervisor must also note the issues that surface in the interactions between the supervisor and the student. These issues often parallel the interactions of the student with family members. By paying atttention to these parallel process issues and modifying her own behavior, the supervisor may influence the student's relationship with the parent. (Bertacchi and Coplon, 1989).

Alice: Understanding the parent's point of view

With Alice, the task of supervision is to find an avenue for empathy with the parenting role. Because Alice is energetic, playful, and responsive, she is able to be very successful in her interventions with each of Amelia's children on an individual basis. But Alice's ability to actively involve Mary (the sad and withdrawn 30-month-old-child) in vocal interaction makes Amelia acutely aware of her inability to engage Mary. Alice's ability to easily seduce Jack (the 15-month-old) only serves to alienate Amelia further from Alice.

Because she does not understand Amelia's experiences as a parent, Alice doesn't realize that she is alienating Amelia. The supervisor may use Alice's and Amelia's similarity in age as one avenue to encourage Alice to develop empathy for Amelia. Alice is asked to consider what it would be like to have two children, and also to consider ways in which Amelia's thinking and needs may be very similar to her own. Alice's youthfulness can be an asset if she is helped to form an alliance with Amelia, to offer friendship, and to share common experiences, such as Amelia's love of music.

With some young, immature students, this approach may backfire. Such students may find so little in common with a parent like Amelia or be threatened by such an identification, that they go to great lengths to differientiate themselves from the parent so that a relationship between the student and parent does not develop. Or the student may act out the role of child with the parent and reinforce immature parental responses.

A structured way to help inexperienced students learn to identify the strengths of a family whose deficits are obvious is to use family-centered principles as a guide. One family-focused principle that Alice is learning is, "Build on any interaction attempts between parent and child." While Alice's first impression is that "Amelia mostly ignores her kids," this principle alerts her to look for any signs of efforts by either the parent or child to elicit the other's attention. Following one supervision session, Alice is able to identify a mismatch in Amelia's and Mary's interaction efforts, noting that Amelia misses Mary's overtures to her and that Mary also misses Amelia's fleeting overtures to Mary.

Additionally, due to Alice's limited experiences, the supervisor models brainstorming techniques for forming hypotheses about and interpreting Amelia's interactions with her children. Alice is asked to consider, for example, how Amelia's apparent passivity toward her children might reflect the circumstances of her social environment and lack of social support. This mutual exploration and problem solving between supervisor and student becomes a model for mutual problem solving between student and parent.

Susanne: Acquiring self knowledge as a basis for work with families

Supervision with Susanne is more directly focused on affective issues. This is all the more challenging because Susanne is unsure about the importance of attending to either the mother's affect or to her own. Feelings of loss from her early experiences in her own family lead her to identify strongly with the very apparent vulnerability of Amelia's daughter, Mary, and even with Amelia. She is able to begin to form an alliance with Amelia. However, this alliance is shaky, as Susanne's unresolved conflicts frequently interfere with her full awareness, and interactions become unclear and communications somewhat convoluted. For example, when things otherwise appear to be going well, Amelia withholds some critical information about Mary's foster placement from Susanne. Susanne's response is to become angry and resistant to working with Amelia. To the supervisor, her response seems disproportionate to what actually had transpired between Amelia and Susanne. Susanne expresses feelings of betrayal; the supervisor suspects that such strong feelings may be be remnants of Susanne's prior experience of loss and betrayal.

The task of supervision with Susanne is to support her so that she can learn to tolerate the powerful feelings that the problems of parents like Amelia trigger in her. The supervisor needs to call attention to Susanne's affect as well as Amelia's in different situations and begin to encourage Susanne to generate interpretations. She may further begin to explore the feelings that Amelia engenders in Susanne by identifying these in herself.

A potential trap in the supervision process with Susanne is the unanticipated power struggle with the supervisor in addition to those with the parent. Susanne becomes angry with the supervisor after the session in which she reveals that Amelia has misled her. She wishes that the supervisor had matched her with a truly resourceful parent and holds the supervisor responsible for teaching her a resourcefulness model for viewing families that she feels she cannot apply to Amelia.

In working with Susanne, the supervisor would do well to remember that Susanne's ability to be a competent and strong advocate of children is her area of strength. By creating a safe, supportive relationship, even in the face of challenge from Susanne, the supervisor can build on the fragile nature of that competence. Susanne is encouraged to "hang in there" with Amelia and when she learns that Amelia's withholding information is based on a very real fear that Mary again will be placed in a foster care home, she is able to see that Amelia needs protection just as her children do. Susanne becomes able to see herself as an advocate for the entire family.

Lindsey: Recognizing the need to be a partner with parents

The task of supervision with Lindsey is in some ways even more formidable. She comes to the supervisory relationship with many strengths, both intellectual and experiential. Lindsey has been a successful parent. She sees Amelia as incompetent, and of course Amelia sees Lindsey as judgmental. This attitudinal set serves to make Amelia even less certain of herself as a parent, giving Lindsey fresh data to support her view that Amelia is emotionally a child and therefore not capable of responsible parental behavior.

Supervision focuses on the assumptions Lindsey makes about Amelia. Videotapes prove useful. Watching her own interventions with Mary and Amelia, Lindsey notices examples of Amelia responding to Mary, behavior that she had not picked up on as it occurred. She also sees herself missing opportunities to support these attempted interactions. The supervisor also challenges Lindsey's assumptions by asking her to examine case material and devise alternate scenarios that might potentially involve Amelia. In this exercise and in other conversations, the supervisor and student jointly identify strategies for avoiding judgments and identifying strengths.

Supervision for Lindsey should help her to direct her natural parenting strengths toward nurturing Amelia. It is important to focus on Lindsey's own parenting experience and the degree to which unresolved feelings or biases about how best to parent influence her work with other families; nurturing Amelia should not lead to a dependent relationship but to a partnership. Thus, in identifying her own parenting priorities, Lindsey is able to see that while a child's speech and language delay might be the most pressing problem that she would identify in her role as a speech pathologist, "this may not be the most important thing for the parent."

Trouble may arise if the supervisor is too directive toward Lindsey or allows Lindsey to be too directive towards her supervisor. Lindsey learns best when self-taught. The parallel process that the supervisor must model is of a partnership, allowing Lindsey to identify her own issues and points of change, while creating opportunities that challenge her less developed perceptions.

Attending to self as supervisor

Supervisors face further challenge in training family-focused early intervention professionals. The supervisor must herself continue to monitor her own feelings and assumptions about families. She must continue to explore her own reactions to families and also to the students with whom she works. What are her own parenting issues? Only in so doing is she able to behave honestly with both clients and students and to model the attitude of self-reflection that underlies all the skills of early intervention (Trout, 1988).

The successful trainee

It is through a complex of systematic interpersonal interactions and training structures that the varied professionals who enter the field of early intervention come to a common ground of empathy for and ability to collaborate with families like Amelia and her children. Alice, Susanne, and Lindsey are themselves in the midst

of a developmental process. The supervision they receive in their interactions with Amelia provides the scaffolding for future encounters with families with diverse strengths and needs. Success for each of them must be evaluated individually and by the standard of how well each will be able to enhance the abilities of these families to meet the special needs of their children.

Once she becomes fully acquainted with the grim realities of the social system that Amelia encounters daily, Alice becomes a strong advocate of system change for Amelia and other families as well as a skilled observer and facilitator of parent-infant interaction. She begins to focus her energies on strategies to make the social environment better for Amelia. Susanne gradually shows more self insight and tolerance for her own feelings for families and children. Her advocacy for children is growing to encompass the family. Lindsey discovers theories that enable her to identify and restrain her own tendencies to "parent" Amelia when transacting with her on an "adult to adult" basis would be more appropriate.

All three students bring to the learning process a variety of skills and experiences and a motivation to change. All three bring attitudes that could create barriers to the forging of true partnerships with parents. But individualized training and supervision enable all three to acquire principles, concepts and skills to help them meet the new standard in early intervention in PL 99-457. All three can move closer to forging effective partnerships with parents, and to helping families enhance the development of their children.

References

Bailey, D.B. (1989). Issues and directions in preparing professionals to work with young handicapped children and their families. In J.J. Gallagher, P.L. Trohanis, & R.M. Clifford (Eds.), *Policy implementation and PL 99-457* (pp. 133-146). Baltimore, MD: Paul Brookes.

Bertacchi, J. & Coplon, J. (1989) The professional use of self in *Zero to Three*, Vol. IX, No. 4, April.

Dunst, C., Trivette, C., & Deal, A. (1988). *Enabling and empowering families*. Cambridge, MA. Brookline Books.

Johnson, B., McGonigel, M. and Kaufmann, R. (1989) *Guidelines and Recommended Practices for the Development of the Individualized Family Service Plan*. Washington, D.C. Association for the Care of Children's Health.

McCollum, J., Thorp, E., & Rowen, L. (1988) "Interdisciplinary Training for Early Intervention: A Philosophy Based Approach." DEC, National Early Childhood Conference on Children with Special Needs. November.

Odom, S.L. (1987) The role of theory in the preparation of professionals in early childhood special education. *Topics in Early Childhood Special Education*, 7(3), 1-11.

Trout, M. (1988). Infant mental health: Monitoring our movement into the twenty-first century. *Infant Mental Health Journal*, 9(3), 191-200.

Teaching and Learning: My First Year as an Advisor at Wheelock College

by

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Sometimes when the telephone rings I don't answer it. That morning I did. It was the speech therapist from the Early Intervention program we had just "graduated" from. She asked if I would be a member of a parents' panel entitled, "Parent Perspectives on the Efficacy of Early Intervention" at a meeting being held in two months. Although the thought of it made me nervous and I had misgivings about my contribution, I agreed to participate.

WHEELOCK COLLEGE

Shortly thereafter, I began to think that maybe I ought to find out a little more about the philosophy behind Early Intervention before I spoke to the professionals in the field. I remembered that there was a student from Wheelock College doing a practicum when my son was in Early Intervention, so I gave the school a call and was connected with Susan McBride, Coordinator of the Early Intervention Program. She said I should come in and she would give me some materials to look over.

I did stop in and besides some books to look at, Susan also mentioned that Wheelock was looking for someone to fill a new position called "Parent Advisor." She gave me a description of the position and an application.

The application asked me to reflect upon our family's interactions with medical, educational and community agencies. It also asked that I comment on what I felt I could contribute to students' understanding of a family's adaptation to having a child with special needs; the role of parents providing services for young children with special needs; and relationships between parents and professionals. And finally, it asked why I would like this position. I really wasn't sure why Wheelock was interested in this information. Why did they want to know about my family's experiences and what did they plan to do with this information? How could this information "qualify" me for a faculty position? And why would I want the job anyway? Although these

questions remained unanswered at the time, I decided to apply.

Applying for the position

Working on the application, addressing all of the issues, helped me to put my son Kevin's deafness in perspective. While it was sometimes painful to go back and remember what we had been through, I found it a very beneficial and positive experience. The application process probably gave me my first opportunity to take the time to step back and examine how far we had come during the past two years and what it had taken to get here. We had gone from being a "normal," relatively carefree, traditional "mother-father-daughter-son" family, and had become a "special needs" family. A family where nothing felt "normal"—where unambivalent, carefree feelings were something hard to remember.

The question on the application that was the most difficult was: why did I want the position? Why did I?. Should I give the reasons that were probably the truest? Say it was because I missed working, that I was ready to look for a part time job again; say that I wondered if I could write a good enough application to get asked for an interview; say that I wondered how I would do in an interview, that it was in large part the challenge of the process rather than the position itself? Probably that wouldn't have been the best idea.

Well, maybe I did really care about the field of special education and the training of professionals. I cared about Kevin and his future and this was a part of his future. I guess that was the "real" issue for me—Kevin. I really hadn't up to that point had the energy to think much past our own situation. I hadn't yet been able to actively think about "others" or the "greater good." All of our efforts had been very personally directed. Maybe it was time for me to broaden the scope of my thinking and see issues outside of our own narrow perspective.

I thought back to the time we "learned" of Kevin's hearing loss. It actually had happened rather quickly, seemingly not really a big deal to the doctor who told us the test results over the telephone. He said our one-year-old son was deaf. Told us to get him some hearing aids, the kind that pick up vibrations, because he wouldn't really be able to hear anything anyway. Hearing this news could never be easy, but I knew that the way we were told was particularly insensitive. This man was cruel, I thought, and I hoped he didn't treat all parents in a similar manner. I later found out that many other parents do "learn" of their children's special needs/disabilities in a similar way. This made me think. Maybe if I could just tell students about the insensitivity that many parents were experiencing, it would help to eliminate it. Maybe I could make a difference.

On the job

I got the job and then panicked. What was I doing? No one had really "told" me what to do. What were the expectations? How could I walk into a class and start "teaching"? What would I teach . . . I had no

Components of Family Focused Training at Wheelock College

For careers working with children and families in health care and special education, Early Intervention, Child Life, Teaching Young Children with Special Needs

- **Courses and seminars:** Coursework provides the theoretical basis for understanding family interactions and the complex issues facing families of children with special needs. A family focus is incorporated into required courses in assessment and curriculum. A specific course is offered titled "Family Support: Working with Parents of Children with Special Needs." The Graduate School offers additional coursework in family systems and family interactions that are available as elective coursework. Most courses incorporate experiential learning activities that include interactions with families.

- **Practica:** All students participate in practicum experiences in community preschool and intervention programs or health related facilities. Practica are arranged for students to have interactions with families through case management, home visiting and conferencing.

- **Family Group Supervision:** A seminar is held monthly focusing on family issues that students are experiencing in practica and related clinical work. These sessions provide support to students by allowing them to discuss common issues and concerns related to working with families, to review interaction and problem solve for future work with families.

- **Parent Advisor:** The parent of a child with special needs is part of the faculty and co-teaches several courses. The parent serves as a consultant for both students and faculty. This position provides a family perspective to the training program and models parent-professional collaboration in our approach to training. (See related article)

- **Interactive Seminar:** This is a 1-credit course in which students in all three programs are enrolled. The purpose is to familiarize students with the principles and practices of each others' professions. The format of the seminar varies from a series of "educational evenings" to a one day workshop. The topic has a cross-disciplinary focus related to families. In the past, these special events have included: "Growing Up Together: Brothers and Sisters of Children with Special Needs"; "Old Traditions and New Roles: Fathering in Families with a Child with Special Needs", "Family Stories: A Pathway for Understanding".

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knowledge of the "field." I only had my experiences and the shared experiences of other families. I remember my first day in class. Here I was, the "expert." Expert what, I thought? But I was supposed to talk about some of my experiences and I did. I started by telling my family's story. I told about the "cruel" doctor. And I was amazed. The students were interested and surprised and concerned by the things I said. And I was interested and surprised and concerned by the things they said. I learned that not only did students have misconceptions about parents, but I had made some inaccurate assumptions about professionals as well. Much of what was construed by me and other parents as cold, unfeeling, insensitive interactions with professionals may really have been fear, discomfort, or lack of knowledge on the part of the professional. I had assumed that these "emerging young professionals" I was talking with were able to interact with families in a comfortable, supportive, honest manner; but I had assumed wrong. They were interested and eager to learn about families and feelings and experiences, but really felt very threatened by many of the emotional aspects they were going to be facing. They were very receptive and grateful that this training program had provided a parent to speak openly and candidly with them. And over the course of the year I was grateful to have the opportunity to talk about a family's perspective on many of the issues they were learning about.

The first term I visited several different classes. The students were being taught how to do various assessments with children and how to write a clear, concise educational plan for a child; but did they know what assessments or educational plans meant to the parents? Did they know how threatening and scary it feels to sit and watch while someone spends a short time with their child and gives him unfamiliar tests to determine what his abilities are ... at what "age level" he is functioning? Did they know that parents often feel that they are being judged when a child is assessed ... that if their child "does not do well" that they have failed as parents ... that if assessments and reports only show what the child cannot do, the parents feel defeated, alienated, and unable to make a difference in their child's life? How could they know that unless someone who had gone through it could tell them about it? And that's what I decided I could do. I didn't have to be "the expert" with all the answers. I could just give students a different perspective on some of the issues and theories that they would be studying; let them "experience" what the parent may be feeling ... share the emotional side as well as the practical side of being a parent of a child with special needs.

I remember in one class a student was complaining about the mother of a two-year-old boy with Down syndrome. The boy was enrolled in an Early Intervention program where she was doing her practicum. Although the boy was severely developmentally delayed, he was cute, smiley, and cuddly. The student loved to sit and talk to the boy, tickle him, and play with him on the floor during the hours he was there each week; but she was angry because this parent did not share her enthusiasm. The mother often cried and only spoke of her son's shortcomings. She did not celebrate his achievements or find satisfaction in his small gains.

I tried to provide another perspective. I reminded the student that she had chosen to work with children with special needs. Her sense of self worth was probably enhanced by her work and her self esteem was probably very high as she left for home each night. The mother, most likely, had not had that choice to make. At this time, it was possible that the child did not provide positive reinforcement for the mother. To the contrary, the parent may have been feeling angry, guilty, sad, or depressed. I told her about an experience I had had a couple of years before. My son's speech therapist was very pleased with Kevin's improvement in breath control. She eagerly told me of the progress in their session. Unfortunately at that time I was unable to share her enthusiasm. So what if his breath control was better? He still couldn't hear.

I suggested to the student that rather than judge that mother, she continue to be positive in her attitude, yet supportive and accepting of the mother's feelings and situation. I explained that parents often begin parenting a child with special needs in an angry or confused state. They were looking for answers, solutions, people to make everything "all right." These students were the people who would be there at the beginning. The people who would need to be supportive. The people who would help parents to gain confidence;

Comments from Wheelock students

"Jill helped clarify the topics we discussed in class. She brought the theory to reality."

"Jill made it known to all the students that she was there as a resource for us. If you went to her, she would share her valuable opinions."

"I think Jill's position is a very important aspect of the training program ... it would be very one-sided not to have a parent advisor."

"Jill made us comfortable with asking questions about what it was like to live with a child with special needs ... not just a textbook answer".

"In terms of parents' rights Jill helped us to realize that what is obvious to us is not necessarily the obvious to parents."

"Having Jill co-teach the course on family support sensitized us to parent issues and allowed us to 'try out' our ideas with a parent. Jill's encouraging, non-judgmental attitute allowed for a greater openness and alliance that helped me feel more comfortable about working with parents of children with special needs."

who would work with these "new" parents and aid them in learning ways to gain control of the situation and become the decision makers for their children and themselves.

Later during the semester that same student came back and told how she had continued to be positive, but had spent time sitting and listening to the mother. Recently the mother had started being more positive in her outlook and yesterday the mother had commented on how much more independent her son had become and how she was thinking about learning sign language in order to help her son express himself better. The student felt that her support had been helpful and that this mother was now ready to become actively involved in planning her son's program.

Expanding my thinking

I felt good about what I was doing. But, almost suddenly, I realized that during the year my own philosophy had been undergoing change. Through classroom discussions and individual meetings with students I started to think more and more about "the big picture." I no longer felt I was only representing my own experience. I felt a real kinship to the larger "special needs" community and I felt a responsibility toward it. I felt comfortable with the support our family was receiving, but what about other families? Had they been as successful as we were? At Wheelock we were giving students a perspective that incorporated understanding and respect for a family; that would help to insure a healthy, cooperative partnership between parents and professionals. But at the same time I realized that enlightened, well-intentioned professionals could do only so much, parents also had to help each other.

Acting upon this emerging philosophy, I participated in training programs which prepared me to do Special Education Basic Rights Training with parents and also trained me as a parent consultant, a person who could act as an advocate for parents in situations such as obtaining services, IEP meetings, mediation, etc. Through these programs I have expanded my knowledge and I have gained the confidence I need to increase my contributions to families of children with special needs. Recently I had opportunities to lead a training program for other parents and to act as an advocate for a family in a pretrial hearing. In the spring, I also taught the special education laws to the students in the Wheelock program, interpreting them from a parent's perspective. These experiences gave me considerable personal satisfaction.

Caring about the greater good

I have come full circle. Almost a self-fulfilled prophecy. Two years ago I had "my story." A story that I thought was relevant only to me. But now I know my story is important to tell. While my newly acquired knowledge, gained through interacting with students; talking with academic, social service and medical professionals; reading textbooks, magazines, and journals; and spending time with other parents, gives me some perspective, it is the sharing of my story that has been the most helpful to others and to myself. It is because of my story that I now feel a responsibility toward a larger community—a responsibility that includes assuming the multiple roles of parent, teacher, and advocate. I look forward to this challenge confidently, and although there are still many unanswered questions, I am now beginning to understand why I answered the phone when it rang that morning two years ago.

Comments from Wheelock faculty

"For several students in our programs, who are also parents of children with special needs, Jill's openness about her own experiences helped to create a climate in which other parents could feel comfortable sharing parts of their stories. This often generated very emotional, but always meaningful discussions".

"Jill has helped faculty learn and grow as well; in the process we have modeled parent-professional collaboration for students."

"Professionals need to be reminded of individual families stories too. Otherwise we will find ourselves dealing with 'professionalized' knowledge instead of working with real people's experience".

"For several years I have been talking with students about the role of the parent in the assessment of the child, only getting passive nods of aggreement in return. When Jill told about her experiences with Kevin's assessments, the role she played or wanted to play and how she felt about the professional interactions that she encountered, we were all engrossed. Afterwards the questions flew and discussion was exciting. What a difference!"

"Jill's presence heightened my awareness and sensitivity about the language that I used, the attitude that I portrayed, the generalizations that aren't appropriate—she kept me honest".

A Developmental/Relationship In-Service Training Model for Public Health Nurses Serving Multirisk Infants and Families

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Prince George's County Health Department

In Prince George's County, Maryland, just beyond the borders of the District of Columbia, Community Health Nurses in the Bureau of Child Health Services dedicate 60 percent of their time to home visiting and case management. Their practice involves reaching out to high risk families with young infants who have not been using the health care system or who miss appointments at the county's seven clinics. These Public Health Nurses are seeing families with more complex needs and difficulties than was formerly the case. Fifteen percent of the infants born in the county were probably exposed to illicit drugs in utero. Almost 11 percent (1290) of the county's births each year are to teen parents; more than a third are to single mothers.

Young children and families whose problems include maternal drug abuse, infant drug exposure, low birthweight, failure to thrive, potential child abuse or neglect, non-compliance with medication regimens, and cognitive impairments create new demands and anxieties for Community Health Nurses as they do for other human services professionals. Work with such families also calls into question traditional Public Health Nursing approaches and rewards. Nurses who have been trained to provide preventive care and information for parents to use in caring for their children find that this model of practice often does not meet family needs. Multiply stressed families fail to keep appointments; may not remember child care information; nod in response to suggestions but do not follow through; seldom if ever express appreciation for the nurse's help; and may even be hostile and angry when pursued. These families, with overwhelming, multiple, complex problems place their infants at great health and developmental risk; to intervene effectively, providers need new skills and insights.

This set of circumstances, in which practitioners are challenged to redefine themselves and the meaning of their work, would be described by adult learning theorists as a state of "cognitive disequilibrium." Stressful as it may be, disequilibrium is seen as necessary to bring about the kind of change in perspective that can, in turn, change the way individuals experience, interpret, and understand their world (Mezirow, 1979).

Many thanks to Ann Kelley, B.S.N., R.N., and Esther Herman, M.S.W., of Protective Services; the planning committee; and the nurses and social workers whose participation in this training program allowed us all to learn.

In Prince George's County, in 1987, Community Health Nurses responded to the markedly changed demands on their professional capabilities by requesting a training program that would assist them in providing more effective services to multirisk infants and families. The Program Director sought out and requested the assistance of a clinical infant psychologist with extensive experience in dealing with low-income, multiproblem families and infants with developmental difficulties. This article will describe the process she initiated of conceptualizing and implementing a training model for Public Health Nurses and Protective Services Workers. The "Developmental/Relationship Training Model" builds on the conviction that it is the quality of the relationship between professional and parent that determines the likelihood of parental changes in behavior to benefit the care and development of the infant. Training must stress the importance of the worker/parent relationship in accomplishing infant care and parenting goals and must sensitize and instruct workers in the insights and techniques required to establish such a supportive relationship.

Defining the work, defining the training needs

A planning committee of nurses, supervisors and administrators met to explore the concerns raised by working with increasing numbers of infants and young children in multiproblem homes in high risk communities, and to define what they wanted to learn. They spoke for nurses all over the county; common concerns seemed to be independent of age and experience. Interestingly, discussion did not focus on specific knowledge or information that nurses could learn and impart to families; rather nurses wanted to know how to motivate and help families use existing information and services, use the nurses' help in supporting the attachment and development of their infants, and identify health and developmental problems as early as possible. Some specific questions were raised:

- **Suppose I only have one chance to engage a family and guess wrong about a baby's safety?** When called upon by Protective Services Workers to evaluate a home or when dealing with a crisis, particularly in areas where their personal safety was a real concern, nurses, like other human services professionals, frequently found problems so overwhelming that it was difficult to know what they were dealing with, let alone whether they were doing their job well. They worried that they might get only one chance to engage a family who did not want them in the home, and that they might misjudge an infant's safety.

- **How do I decide whom to see and whom not to see?** Nurses found that increasing caseloads and increasing complexity caused a constant redefinition of administrative priorities. Finding a balance between easier and more difficult families was unlikely. The comments, "You have seen her long enough" or "She

is too dependent on you" would be heard. Nurses wondered whether families were being discharged fro the wrong reasons—increased staff anxiety, rather than improved function. But they also wondered whether they might be persisting with families for the wrong reasons—a need to "make" something work to protect one's professional self-image

- **How, day by day, do I work with difficult families?** Nurses wondered how to promote attachment when they saw so many babies failing to bond with their mothers, how to help highly stressed, drug-using mothers care for drug-exposed infants so fussy and irritable that even the best mother would be at a loss. They wondered what to do when parents did not show up for their appointments or said they would do something and didn't. They asked how to compete with the television for a mother's attention and how to respond to a grandmother who asked that Protective Services be called to investigate her daughter.

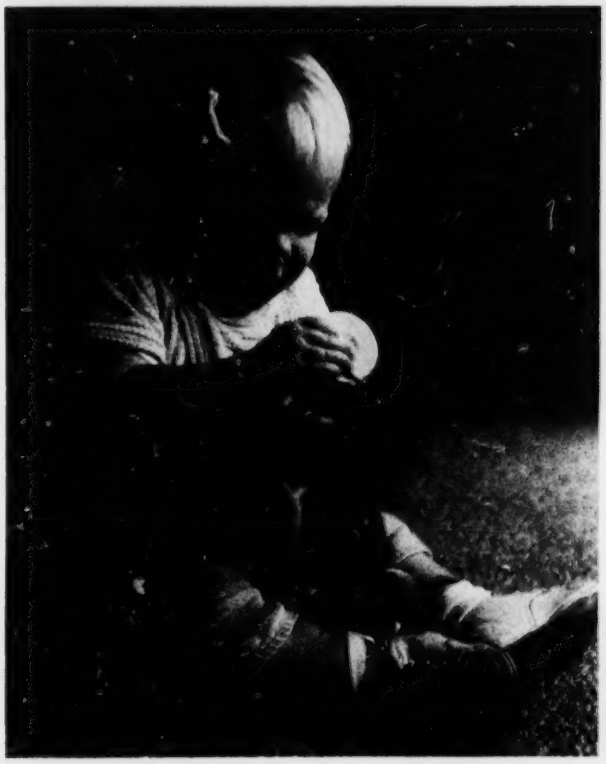
A major concern was how to set **realistic** goals for families that accurately reflected their capabilities.

Most professional in-service training efforts attempt to impart information, enhance competencies and provide a forum in which nurses can share experiences and meet with colleagues. However, the relevance and utility of the knowledge and ideas imparted are often undertain, and the impact on families ambiguous. Now, given the opportunity to define what they wanted to learn to support daily nursing practice, the Community Health Nurses sought a more differentiated view of the work and their professional role. In order to engage and motivate families more effectively, they wanted to better understand both their families and themselves. Above all, they wanted to know how they could know that they were doing their work well and how practically to measure success or failure.

What proved to be essential for the trainer was expertise on how people learn, change, and use relationships to develop. By staying focused on this **process,** the trainer could integrate the specific "topical" knowledge nurses wanted on development, interaction, play, the impct of drug exposure, etc. into the ongoing training program. While it might have been possible to have a number of specialized experts present at large meetings, the training model would still have required someone to "personalize" the knowledge presented, tying it to participants' thoughts and feelings in both small and large sessions. The continuity provided by single trainer also meant that the consistency and persuasiveness of the basic "message" concerning the importance of relationships could be delivered in many different ways, as the nurses discussed and examined their ideas and feelings. By seeing the participants each month, the trainer got to know their strengths, special talents, knowledge base, concerns, resistances and anxieties, and could address these issues.

A conceptual framework for training

Researchers in education describe developmental levels of conceptual functioning and relate these levels



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to specific behaviors among practitioners (Harvey, 1966; Murphy and Brown, 1970). For example, in stage one, practitioners value authority and believe that any question has a single right answer. Stage two is characterized by uncertainty, but behavior does not alter. In stage three, practitioners tend to use group consensus rather than established rules to guide behavior. In stage four, individuals regard knowledge as tentative rather than absolute and are able to consider situations from different points of view. Researchers describe this stage of development as characterized by increased flexibility, differentiation, tolerance for conflict and ambiguity, and comfort with conceptual complexity, characteristics that enhance both interpersonal functioning and effectiveness at work (Hunt, Kohlberg and Loevinger, reviewed by Glassberg and Oja, 1981).

Can an in-service training program promote such development? That was the challenge the planning committee faced. We needed to make training an opportunity to understand the work being done, to support it, and to learn from it. Nurses had described very substantial challenges to their practice; the training program would have to present a conceptual framework that would be relevant to their work. We sought to create a training model that would enhance the functional practice level of Child Health Nurses in the program. We needed to help staff go beyond trying to use familiar terms to interpret new experiences and challenges; we needed to help them become able to identify and respond empathetically to difficult, frequently ambiguous situations and emotions in more self-confident and realistic ways.

Development during the earliest years of life, when parent-infant relationships and feelings provide a foundation for learning, offered a conceptual framework highly relevant to Community Nursing practice with young children and families. The parent's caregiving and attention to health issues in the child present a process that is parallel to the nurse's efforts to engage challenging families. Therefore, in our training program, we wanted to make sure that not only the content, bu the structure and process of training as well, would embody a developmental perspective.

Goals, structure and content of the training program

This training was designed to build upon the strengths of the Community Health Nurses. Some staff had already intuited ways to use their own strengths and support form colleagues to deal effectively with difficult families. We sought to create an environment in which all nurses could build upon their own and one another's expertise. The nurses met to define for themselves what they wanted to learn, developed the curriculum to address areas of greatest needs, evaluated the training midway, and revised the curriculum and approaches accordingly.

We set both affective/relationship and behavioral objectives for training. Affective objectives included the development by nurses of a more complex, differentiated, and integrated understanding of themselves and the families with whom they were working. Behavioral objectives included an increase in knowledge about child and parent development; the enhancement of skill in promoting interaction and positive relationships between infants and parents; and the development of strategies that would allow a nurse to assume a variety of roles with families, depending upon the circumstances.

The developing relationship between the trainer and the nurses proved central to meeting the affective objectives of the training. We realized that this relationship would need to include the same elements we wanted to see in relationships between nurses and families and, more important, between parents and infants. Toward this end, the trainer met with the entire "family," from the Chief of Child Health Services, to the Assistant Chief and Professional Development Specialists, to District Supervisors, to Nurses. This process produced a sense of total commitment within the Bureau of Child Health Services to common goals. Approximately 50 Protective Services Workers and Nurses attended the large group lectures and later divided into three smaller District case conference sessions with 15-20 staff. Furthermore, the trainer made home visits with nurses to families identified as particularly difficult to work with; this practice allowed the trainer to join the nurse's efforts as well as to better understand the reality of the nurse's work. Finally, the trainer was responsive to the personal as well as the professional concerns that the nurse expressed.

The structure of the training program, like its goals, was arrived at through discussion. Like development, the training program was designed to be an unfolding process. Conducting training over a ten-month period permitted practice, application, and integration of content. Different approaches were designed to accommodate the different ways people learn. Large group lectures and discussions, role playing, small group case conferences, readings, and accompanied home visits complemented each other and offered nurses different ways to learn and participate. Role playing offered an opportunity to practice active listening and emphatic responding. Home visiting, where so much of the nurse's work actually is done, offered an opportunity for applying new learning.

The range of experiences and opportunities offered within the overall training program were designed to relate to each other and to validate the important work that the nurses were doing. By experiencing together meetings or home visits that had some emotional intensity or significance, the learners and the trainer developed a sense of "shared meaning" about what had occurred. Over time, it was no longer necessary to spell out everything in words—a look or a "shorthand" phrase could convey what was important about an experience, or how it felt. Shared meanings, achieved through a variety of shared experiences, were also the essence of what would need to be developed between nurses and mothers, and mothers and infants, for learning and development to proceed.

Implementing the training program

Between 50 and 60 people participated in the training program, including **all** the Child Health staff and about ten Protective Services Workers, including three supervisors, who had been invited to joint the training program so that they and the nurses could better understand each other's work.

During the ten-month course of the training initiative, five bimonthly large group lecture and discussion sessions were held. These day-long events were used to present a variety of interrelated material regarding infant development, parent-infant interaction, nurse-parent relationships, and the specific challenges involved in working with adolescent or drug-abusing parents and their babies. Theoretical and conceptual frameworks such as Greenspan's developmental-structuralist model (1981) and Klein and Feuerstein's mediated learning experience (1985) provided the structure to undergird new perspectives. The close connection between training topics and the professional concerns that the nurses had identified led to active participation in discussions, role playing and responses to provocative videotapes. The focus always remained on the work to be done—intervention strategies and specific techniques to engage and promote interaction—and on the nurses' experience in doing this work. (See p. 21 for approaches to mediating successful parenting, as presented by Wieder during the course).

Case conferences, conducted at three District Centers, allowed for more interaction within groups

of no more than twenty staff. The cases selected through discussion between supervisor and staff were often those that presented exceedingly difficult problems and left nurses feeling "stuck," uncertain about how or whether to proceed; these cases were also selected because they confronted the nurses with their own strong feelings, ranging from protectiveness to anger, fear, and the bitterness accompanying failed expectations.

The case conference format provided an excellent opportunity to examine the complexity of each situation and the nurses' need for increased flexibility, tolerance of ambiguity and acceptance of their own limitations. their understanding of themselves and the families became more differentiated as they could sort out positive and negative feelings, what they identified with in families and what they rejected.

Case conferences also served to validate the significance of the nurses' developing relationships with parents. Conventionally, nurses' productivity and the outcomes of their efforts were typically measured by numbers—of families seen, immunizations completed, referrals made, or records updated. Professional relationships with parents were assumed. The case conferences, however, focused on the **process** of the nurse's work and the importance of her interaction with parents. Developing relationships with parents were emphasized as important goals to be accomplished, since relationships were the vehicle for promoting parents' abilities to support the physical health and development of their children.

In the course of the case conferences, certain responses to work with infants in multiproblem families emerged as typical. The examination of these responses, within the case presentations, provided the substantive content of training.

1. Nurses often underestimated the importance of the relationships that they had managed to establish, often through persistent outreach.

2. Nurses tended to see strong feelings about families—either positive or negative—as evidence that they were getting "too involved." Some did not consider their reactions in relation either to the specific effect parents had on them or to their own expectations or attitudes.

3. Nurses were often so consumed during case conferences by efforts to decipher the overwhelming, anxiety-producing family "dramas" they encountered that sometimes the infant in the family was lost to their attention.

4. Because very little interaction or "play" occurred between either parents and infants or nurses and infants during their contacts, opportunities for pleasure and reciprocity were missed that could have helped to strengthen all the relationshps involved.

5. On occasion, giving information and instructions could serve as a defense against getting closer to a frightening family or environment.

6. When family problems seemed overwhelming, family strengths were often overlooked. Similarly, nurses tended to lose sight of their own strengths and successes.

7. Focusing on psychpathology created a safe distance and was used to alleviate insecurity about being able to help certain parents.

8. Nurses often felt pressured to find solutions to insoluble problems; when they could not, they would tend to withdraw before giving themselves a chance to review what was going on and learn from the experience.

9. The nurses had a unique opportunity to facilitate "successful" parenting, which would provide an important source of self-esteem to parents facing future challenges.

Each case presented was discussed by the trainer in terms of the developmental and therapeutic relationship issues (Greenspan and Wieder, 1984) raised. Each case provided an opportunity to recognize strengths and challenges and to support the nurses' efforts. While the child and family's "story" was certainly important, the conference also focused on **how** to think about the family. The trainer tried to help participants conceptualize each situation with regard to the process of engagement, the differences between the perceptions of the family and those of the nurses, the feelings triggered in the nurses as indicators of the family's experience, the expectations of nurses and families, and how they affected each other. As we shared what different ideas and behaviors of each family might mean and the experience of working with them, the nurses could shift perspective. They could return to the case with renewed energy and redefined goals. After the case conferences, they could more readily apply the knowledge of infant development and skills to promote interaction and positive relationships that they had learned in the larger sessions.

Home visits where the trainer accompanied the nurses provided the most individualized learning opportunity for nurse and trainer to work together to address concerns about a family. These visits were used to evaluate further the developmental levels of infants and parents, their interaction, and the approach being used to engage the family. By bringing toys and books, the trainer could also model specific techniques for the nurses, such as inviting both parent and children to "play;" encouraging the parenting identity in talking with the parent, and leaving a special notebook with pictures and ideas; singing songs; and noticing the strengths of the infant. These visits became the opportunity to introduce new ideas and to help parents experience a sense of success and pleasure through interaction with the child. Following the visit, trainer and nurse could discuss the dynamics of the intervention, the stage-specific issues, the next steps in development, and the methods needed to engage families' attention, facilitate reciprocity, and, most importantly, to play and have fun together. Only by taking the time together to play and mediate pleasure and success would parents come to believe that this was important.

These home visits were also discussed in small group meetings whenever possible. The willingness of the trainer actually to go on home visits with the nurses, sharing their concerns and dangers, provided credibility and support for this special aspect of their work.

Any service system should include learning opportunities for every level of staff. As part of our training program we planned a special session for nursing and protective service supervisors, to address the specicic stresses and challenges present in their work. Here, too, the developmental/relationship perspective was helpful; supervisors were able to consider alternatives to unrealistic expectations that they held for themselves—that they had to have all the answers, absorb all of the their staff's anxieties, or be the sole source of protection and support for staff in the system.

Evaluating the training program

Evaluating a training program is probably no less complex than evaluating a service program. In evaluating the Child Health Nursing training effort, it would have been ideal to address changes in the nurses' professional developmental level, observable changes in actual practice, changes in nurses' professional self-image and perceptions of their own work, and the impact of the training program on parents and infants. Unfortunately, limited resources did not permit a systematic study of these complex issues. However, informal observations and feedback from the nurses indicated that the more receptive nurses were to looking at themselves and to new learning, the more confident and competent they felt, the more they enjoyed their work, and the less likely they were to leave the unit.

The trainer and planning committee learned a great deal from the nurses' own evaluations of the training, which occurred in the middle and at the end of the ten-month program. Using a five point scale from exceptional to unsatisfactory, the nurses rated the overall quality of the course, the various training formats, and the usefulness of content. That ratings became more positive from the middle to the end of the program may reflect the developing relationship between nurses and trainer. All the participants found the overall program interesting, with large majorities also finding it relevant to their work (89%) and being able to apply course content (86%). Small group case conferences and home visits were rated highest among training formats, followed by large group lecture/discussions and nurse presentations. The readings seemed to be the least useful way for participants to learn. A follow-up study will examine what aspects of the training nurses continue to find useful and how nurses may have changed their perspectives and perceptions of their work.

Conclusions

Our training program, planned in three months and implemented over a ten-month period, attempted to integrate adult learning and developmental/relationship models in order to address the training needs identified by Health Department Child Health Nurses and Protective Services Workers in Prince George's County, Maryland. The training model seems particularly appropriate for in-service staff development programs in which a group that faces common work issues can meet together over time.

The features of our model included:

- a conceptual framework for the goals of the training, with affective and behavioral objectives to guide the training and efforts to increase participants' developmental level;
- definition by the participants of what they wanted to learn and the personal and professional challenges presented by their work;
- a variety of training approaches that addressed individual learning styles and provided opportunities to practice and integrate the concepts being presented;
- active participation by the trainees in the learning process, through discussions, case presentations, role playing, and presenting; validation, through these activities, of trainees' strengths and abilities to organize their own learning;
- joint learning by staff of several agencies, with the goal of developing mutual understanding of each other's work in order to reduce professional and interagency tensions and facilitate collaboration;
- an emphasis on direct interaction and play with mothers and babies as the means to promote relationships which support health and development;
- an extended training period, which permitted relationships, as well as new perspectives to develop over time.

Finally, learning is an ongoing process. It supports and rewards the practitioner's daily work. The new initiatives undertaken in their practice and interest in further learning that we have observed among participants in our training program suggest that our model opened doors to individual learning. We could not ask for a more satisfying outcome.

References

Glassberg, S., & Oja, S.N. (1981). A developmental model for enhancing teachers' personal growth. *J. Research & Development in Education, 14,* 59-70.

Greenspan, S. with Greenspan, N. (1989). *The Essential Partnership,* NY: Viking.

Greenspan, S., & Lourie, R.S. (1981). Developmental structuralist approach to the classification of adaptive and pathologic personality organization: application to infancy and early childhood. *Am. J. Psychiatry,* 138:6.

Greenspan, S. & Wieder, S. (1984). Dimensions and levels of the therapeutic process. *Psychotherapy,* 21, No.1.

Harvey, O.J. (Ed.) (1966). *Experiences, Structure and Adaptability.* NY: Springer Publishing Co. Inc.

Klein, P. & Feuerstein, R. (1985). Environmental Variables and cognitive development. In Harel, S. & Anastasiow, N. (Eds.), *The At-Risk Infant: Psycho/Socio/Medical Aspects.* Baltimore: Paul H. Brookes, Inc.

Klein, P.; Wieder, S.: and Greenspan, S. (1987). Prediction from mother-infant interaction patterns to preschool performance based on observations of mediated learning experience. *Infant Mental Health Journal, 8, 2,* 110-129.

Mezirow, J. (1979). Perspective transformation. *Adult Education,* 28 (2), 100-110.

Murphy, P. & Brown, M. (1970) Conceptual systems and teaching styles. *American Educational Research J., 7,* 529-540.

Rogers, M.E. (1989). Creating a climate for the implementation of a nursing conceptual framework. *J. Continuing Education in Nursing, 20,* (3), 112-116.

Mediating Successful Parenting: Guidelines for Practitioners

by Serena Wieder

Parents learn to be parents in many ways. Some read books, pamphlets or magazines available at every check-out counter. Others watch T.V. talk shows, talk to their friends or neighbors, call their mothers, or remember their own childhoods. Still others take courses and join other new parents. Hopefully, all learn from their infants as they care for them, enjoy them, and grow together.

At risk parents are often unable to use these resources to learn. They may be distressed by overwhelming realities, overwhelming pasts, and previous failures and fears which continue to interfere with their functioning in general, and as parents in particular. Too often they do not have the chance to enjoy what other parents enjoy with their children, singing songs, dressing up, taking pictures, or playing.

Whatever the structure or goals of an intervention program, working with these parents and infants involves interacting and relating in many ways. Specific techniques are described below to mediate more successful parenting. They are derived from therapeutic and mediated learning experience models which can be integrated into common interactions and play during time spent together.

Give the concept of being a mother or father positive meaning and identity—build consciousness and awareness of being a parent. It is important not to assume that having a child means feeling like a parent. Even if someone begins to feel like a parent, nurture this new identity with as much support as possible. This is done by admiring the parents, giving them credit for what they do, having fun together with the infant, and reassuring them the child is doing well. To do this, indirect comments are useful. For example, when seeing a baby who is dressed nicely or is attractive, one might say to the baby being held by the mother, "Mommy dressed you so beautifully today; she knows exactly what looks good on you!" Or, "You're so big, Mommy knows exactly what/how to feed you to make you grow!" Or, "Mommy knows how to dress you beautifully Suzy, you're a lucky girl!" Or, "What an athlete Daddy is making out of you." Such comments help a parent feel proud; focus on the process of what they have to do to feel competent; and lessen the risk of parental jealousy of the infant. One does not assume the parents appreciate or take pleasure in having their child admired when they are not directly credited or referred to.

Make the mother and father feel unique. To support the special attachment and investment parents need to make in their infants, reinforce the uniqueness of the parent to the child. This too can be done through a variety of comments to the parent, such as, "Mommy gets the best smiles from you; I know who is in love with you!" as the baby smiles at the parent. Similarly, when noting the baby looking at a new or strange face, say, "You sure know your mommy best of all because I can see you staring at me and you don't know me at all!" In the course of the following an infant, many opportunities arise which can highlight the parents' unique function. For example, when a baby fusses the intervenor might say, "Mommy will know how to comfort you best of all," as you guide or support the parents' response to calm the infant. Here too is an opportunity to give the parents credit for anything they do, for the purpose of enhancing their special relationship with the child and supporting their self-esteem.

Focus on the infant's or parent's experience rather than right or wrong. It is possible to communicate to the parent that infants have feelings and experience things in different ways through straightforward comments or "talking through the baby." For example, one might say "Hold me tight; I like to be all wrapped up tightly too." Or,

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"Don't turn me so fast; it's scary and I'm afraid I'll fall." Noticing how the infant might be feeling is especially important for the parent who does not empathize readily, or does not think in terms of the infant's feelings, or may not be handling the baby very well and does not notice the effect she or he is having. Such comments support the parent's efforts without the practitioner's taking over or necessarily knowing what is going to work best. This approach encourages exploring different attempts to calm the baby by reading signals with the parent and relating to these signals as expressions of feelings.

Focus on issues relevant to the infant's specific stage of development. For example, when helping parents learn to read the baby's cues and signals as they begin to communicate in purposeful ways, highlight the meaning of these behaviors. For example, "You want to tell mommy something, don't you?" Or, "Figuring out what you want isn't easy at all; tell/show mommy what you want again." "Oh, look how he turns around to look at you just after he crawled away; he wants to make sure you're still there!" "Boy, you need your daddy's help, don't you, it's hard!" Such comments accomplish multiple things. They focus on what is important for the parent

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to respond to at specific stages. They preempt misinterpretations of the meaning of behavior which can lead some parents to withdraw or reject or retaliate against their children if they disapprove. It is also easier for parents to learn an infant's language if they feel it is directed towards them. These comments support the attechment, identity and uniqueness of the parent.

Focus on the impact of current behavior on the future. With parents who do not relate current development to later achievement or success, or parents who have little sense or hope for the future because of being overwhelmed in the present, it is useful to create a sense of future success for the infant and the role parents can play. For example, when encouraging reading baby books, you might say, "When you grow up, you will be so smart because mommy is getting you ready already!" Or, when observing a child play with blocks, "I wonder if you will be an engineer or an architect, you build those blocks so well!" Or, "Daddy is so good with tools and you are following his footsteps already." encouraging the ability to transcend the present is important so that parents identify infant learning with future success in school or work. But it is important to focus on the *process* of learning and not the product, i.e., discovering, exploring, trying new things, using toys or objects in novel ways, rather than being able to name letters, numbers and other concrete skills.

Build parental self-esteem by selecting and admiring success. Whenever a child is doing something well, it is worthwhile pointing that out and building an image of the child as a successful learner and the parent as a successful parent who can be effective and help the child learn. General admiration or clapping such as, "That's great!" or "You're so good!" is not as useful as specifying what made the act successful or what difference it makes. For example, if a toddler is stacking rings, then he might be admired for, "you figured out which one should come first and second and thirds; that's good thinking!" Even if the child cannot yet understand these words, commenting guides the parent to think in terms of thinking and problem solving rather than just the end product which may or may not be well done. Focusing on the process of how or why something succeeds encourages the parent to pay attention to what to do, rather than what they will get or other concrete results. For example, admire the parent's success in getting the child to attend, "You really got him to listen when you got him to look at you before telling him what to do." When these behaviors are noticed in the course of natural interaction they convey the idea learning is going on all the time. They also put the parent in charge and reinforce effective behaviors rather than only focusing on problems and parents' inadequacies.

Family Administrated Neonatal Activities: An Innovative Component of Family-Centered Care

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From the moment of birth, parental interactions with their infants are guided by their perceptions of the baby. These perceptions are influenced not only by the actual behavior and observable characteristics of the newborn but also by the parents' own memories and experiences (Cramer & Stern, 1988; Zeanah & Anders, 1987; Wright, 1986). Family Administrated Neonatal Activities (the FANA), a specialized application of the Brazelton Neonatal Behavioral Assessment Scale (NBAS) (Brazelton, 1973), is designed to influence three critical components of the parents' "working model" for interaction with their baby: 1) the parents' capacity to observe their newborn; 2) the meaning that parents ascribe to their observations; and 3) their sensed competence or self-esteem as parents. The FANA provides a specific clinical protocol for a family-administered NBAS which intergrates the practices of focused psychodynamic interviewing with the principles of parent empowerment. Within this context, parents are helped to articulate their initial perceptions of their newborn, and then to use the behavior of the baby as the vehicle through which they can affirm or challenge their initial perceptions. By contributing to the authenticity of parents' working models, the FANA experience can help to organize parental behavior along a growth-promoting course.

This article places the FANA in the context of earlier applications of the Brazelton Neonatal Behavioral Assessment Scale; describes the structure of the FANA experience; delineates the role of the FANA facilitator; and suggests clinical applications of the FANA.

Building on the NBAS

The clinical model of the FANA was influenced by earlier efforts to use the NBAS as an intervention tool. Originally developed as a research instrument, the NBAS has been used with new parents to teach them about the behaviors of their newborns. Typically the role of the examiner has been to handle the infant, administer the items, and then describe and interpret the infant's responses to the parent (Nugent, 1985). Variations of family-administered NBAS experiences have been designed for low-income, black teen mothers; middle-income mothers and fathers; and parents of low-birthweight infants. These interventions have been found to promote parent/child interactions; increase performance on measures of cognitive development; strengthen parents' recall of infant behaviors; increase parental involvement in caretaking; and enhance maternal role satisfaction and self-confidence. (Widmayer & Field, 1981; Myers, 1982; Woroby and Belsky, 1982; Belsky, 1985, 198; Nurcombe, Howell, Rauh, Teti, Rouff, & Brennan, 1984; Rauh, Achenback, Nurcombe, Howell, & Teti, 1988).

The nature of the parent's experience with the NBAS, rather than the NBAS itself, seems to influence the outcome in these interventions. In their 1988 review of family-focused intervention studies, Heinicke, Beckwith and Thompson examine six studies using the NBAS. Two studies, in which the parents were observers only, were not successful in producing positive and significant findings; three of four studies in which the parents were active participants were successful in producing such outcomes.

The FANA represents a significant departure from the parental experience in the examiner-as-teacher/expert, parent-as-learner model of previous investigators. Two distinctive features characterize the FANA: 1) the FANA is based on a model of parent competence; and 2) the FANA is a clinical rather than an educational model—i.e., the facilitator is trained to respond to the parents' interpretations of the baby, rather than to interpret the baby to the parents.

The FANA is designed so that the parents are sources of knowledge about their baby, rather than recipients of the expertise of others. The activities of the NBAS are used not to teach about infant behavior, but to elicit and discuss parent perceptions of and observations about the infant's capabilities. The process allows parents to draw on their own observations of the infant's behavior to recalibrate their initial perceptions of their newborn. According to the evolving literature on the helping process, people are likely to engage with professionals in helping relationships if they feel that they themselves are producing results (Dunst and Trivette, in press). Conceptually, then, the FANA may engage parents more powerfully than other NBAS interventions which, while nominally "parent-administered," nevertheless relied on direct instructions by the professional and compliance with modeled behavior by the parent.

The FANA facilitator attends to the here-and-now needs, concerns, and strengths of new parents, unlike the examiner in previous family-administered NBAS efforts. This clinical piece of the FANA—responding to the parents' responses—is, we believe, critical to the effectiveness of our model and to the training of facilitators. The FANA attempts to help parents begin to address and resolve important issues of the perinatal period by incorporating into the protocol practices from classic psychotherapeutic interviewing; these are designed to elicit the family's sense of their personal well-being, situational stresses surrounding labor and delivery, and their personal interpretations of their infant. As a trained clinical practitioner as well as an

Portions of this article will be published in a forthcoming issue of the Infant Mental Health Journal. For information about the journal, contact Joy D. Osofsky, Louisiana State University Medical Center, 1542 Tulane Avenue, New Orleans, LA 70112.

infant development specialist, the FANA facilitator has developed skills which allow for the rapid integration and use of these aspects of the parental experience.

Family Administered Neonatal Activities: Development, purpose and content

The FANA was developed in 1986 and implemented in 1987 as a new component of the Infant Care Program, a family support program sponsored by the Departments of Obstetrics and Pediatrics, Evanston Hospital, Evanston, Illinois. The FANA lasts 35-40 minutes and typically is conducted on the second day postpartum in the mother's hospital room, with mother, father, and infant present. The FANA is routinely offered to all of the approximately 1200 first-time parents who deliver at the hospital each year. Up to 68 percent of these families request the FANA. The FANA is also offered to any family that in the opinion of staff physicians, nurses or social workers may be experiencing difficulty in adjustment to their roles as new parents. Thus the FANA is used as a supportive activity to promote competence and adaptation for families who are coping well with the transition to parenthood; as an intervention for functioning families experiencing situational stresses around the birth of a new baby; and as an assessment where pre-existing or current family issues have raised concern about the family's ablility to care for the infant at home.

The FANA includes four phases: Chart Review, Parent Perception Interview, NBAS Application, and Integrative Summary.

Phase I: Chart Review

Before meeting with the family, the FANA facilitator reviews the mother's and baby's medical charts to cull relevant antecedent parental history including: 1) historical variables such as pregnancy history, prior perinatal losses, prior traumatic labor and delivery, maternal health, and major life stresses; 2) current issues such as mode of delivery, complicated/stressful labor or delivery, and postpartum maternal health, including medications; and 3) infant status variables such as birth weight, gestational age, sex, APGAR scores, infant health post-delivery, and presence of any congenital anomalies. Throughout the FANA experience, the facilitator keeps in mind antecedent history and how this history might affect parents' observation and perception of their newborn as well as their sense of themselves in relation to the infant. The facilitator does not use this information to raise issues; rather, she uses history to inform her listening and her responses to the issues that families themselves express.

Phase II: Parent Perception Interview

The family contact portion of the FANA begins with the Parent Perception Interview. During this 15-20 minute structured interview, each parent is asked to talk about: 1) his or her personal wellbeing; 2) his or her labor and delivery experience; 3) the baby's name and its historical significance; and 4) what he or she has already noticed about the baby. The facilitator's primary role in the interview is to listen and acknowledge parental observations, perceptions, and concerns. The protocol is designed to encourage parents to show a full range of expression. The facilitator is trained **not to**: 1) normalize the experience ("All new mothers feel that way"); 2) provide reassurance ("You'll feel better soon"); or 3) teach new information ("in three or four weeks, your baby will be able to hold his head up more steadily").

For example, when parents describe labor and delivery, their experience is acknowledged as uniquely theirs. Whether it was easy or unexpectedly difficult, the experience is treated as an event in response to which they are entitled to have strong feelings. This stance is one that underlies classic psychotherapeutic interventions: providing parents with the opportunity to articulate and then discharge strong feelings about a major developmental event renders them "owners" of that event and allows them to re-establish a sense of equilibrium and mastery. The Parent Perception Inteview also provides the first in a series of opportunities for the facilitator to acknowledge parental observations of their infant as well as their interpretations of infant behaviors and their parental concerns. By encouraging a discussion designed to lead to some mastery of feelings concerning labor and delivery, by acknowledging existing observational skills, and by accepting the meaning that parents have already ascribed to their observations, the FANA facilitator works to enhance a parental sense of self-esteem. But the FANA experience goes beyond this.

Phase III: NBAS Application

The hands-on portion of the FANA begins with the application of the Neonatal Behavioral Assessment Scale. The purpose of this phase is to make distinct the reality of the infant's present behavior—the infant's reflexes, muscle tone, consolability, and competencies in habituation and interaction with people and objects. During this 15-20 minute experience, parents are guided in eliciting 28 infant responses that have been shown to be particularly engaging to parents. The typical sequence involves observation of the infant's state, habituation, reflexes and orientation. However, as in the NBAS, the order of the items for an individual infant is determined by his or her state.

An important feature of the NBAS Application is the facilitator's consistent, focused attention on the family and on parents' responses to their infant's behavior. The facilitator is trained to wait for the parent's response to an infant's behavior before responding herself. The facilitator then may encourage the parents to reflect on their experience by asking, "What did you see?" or "How did that feel?" She may provide feedback from the point of view of the baby, commenting, "I heard you, Mom!" or "Your baby heard you!"

This concrete, interactive experience with their newborn often serves to affirm parents' initial perceptions and observations, but it can also challenge

them. In either event, the baby becomes, in words parents use repeatedly, a "real person" to the parents.

Phase IV: Integrative Summary

During the Integrative Summary, the facilitator guides a discussion in which parents are encouraged to integrate their initial observations and perceptions of their infant with the behaviors displayed by the baby during the NBAS Application. More often than not, the initial parental perceptions are affirmed by the baby's behavior. At times, the baby's behavior challenges the initial perceptions, and the parents are guided in recalibrating their original "working model." For example, one young father said in the Parent Perception Inteview, "I don't think (the baby) likes me; she cries when I hold her." During the NBAS Application, this father was able to elicit visual following as he looked into his daughter's eyes and followed his face through a 45-degree arc; he saw her head turn quickly in his direction as he called her name. He also experienced her crying as just one of six states, and he saw that he could help considerably in soothing her when she did cry. During the NBAS Application, the facilitator periodically asked the father, "What did you see?" or "What do you make of it?" In the Integrative Summary, the father was encouraged to draw his own conclusions regarding his initial concerns, based on his infant's behavior during the NBAS Application. Now the father's comment was, "She really looked at me," as he kissed and cuddled his baby.

The uniqueness of FANA lies in the opportunity it affords for parents to address their perceptions of their infant and to consider those perceptions as they are affirmed or challenged by the here-and-now behavior of the baby.

Role of the facilitator

The FANA facilitator plays a unique role in the hospital setting. In traditional medical model, the physician exercises an authoritarian role based on his or her expertise and control of facilities; the patient is expected to suspend judgement and comply with the prescribed treatment. During pregnancy and particularly during labor and delivery, notwithstanding significant changes in obstetrical practice over the past 25 years, the physician and nurses are granted situational authority, because of their knowledge and skills, by parents who assume situational dependency because of their great need for service they cannot provide for themselves. As one father commented, "When you have a baby, you'll do what anyone tells you. You'll regress." While this regression and dependency are a natural part of the psychophysiological shifts in pregnancy, the hospital environment and culture can exacerbate this regression, particularly when there is an objective or perceived degree of risk.

In contrast, the FANA facilitator's goal is to achieve a more nearly reciprocal relationship with new parents. Reciprocity, rather than professional control, is seen as the therapeutic agent necessary to produce the desired end results of the FANA—i.e., enhanced

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parental self-esteem, observational skills, and a perception of the baby influenced more by the reality of the baby than by the residuals, for example, of a traumatic labor and delivery. Shea and Tronick (1988) caution practitioners who wish to develop parental self-esteem against falling into the trap of telling parents what to do. The FANA facilitator uses her expertise not to instruct or prescribe, but rather to elicit, acknowledge, guide, and reflect.

The FANA model helps new parents to shift from a situation in which competence resides, to a large extent, "outside", with professionals, to a model in which competence lies within themselves. The FANA model provides a first-hand experience in a more symmetrical parent/professional relationship. Clearly, marked changes have occurred in obstetrical practice in recent years which focus on empowering parents during the perinatal period. Nonetheless, the labor and deliveryy can be so stunning to new parents and the objective circumstances of birth so foreign (e.g. the use of forceps) that parents persist in feeling that power and competence lie "outside" of themselves. "Outside" competence remains available from health care providers, parent educators, and others after the family goes home, but even postdischarge relationships should strive for a balance.

Generic process skills

The FANA facilitator is trained to reliability in two aspects of her role: 1) a set of generic, process skills that are present in each phase of the FANA and 2)

a set of phase-specific skills. The process skills needed throughout the FANA include focused attention on the family, acknowledgement of parental observations and concerns, and encouragement of parents' authority.

The facilitator maintains steady focused attention on the parents by directing conversation toward parental statements or infant behavior. The facilitator neither shares personal anecdotes nor relates the experiences of other families. Rather, through questioning and responsive listening, the trained facilitator encourages parents to reflect on themselves and their own experience.

The facilitator acknowledges parental observations, strengths and concerns throughout the FANA. In contrast to other parent-administered NBAS models, the FANA facilitator does not assume a teaching role. Instead she listens for and acknowledges the observations that parents have already made. The facilitator repeatedly affirms parents' efforts to observe their baby, understand their situation and maintain control. She may comment, for example, "You have noticed a lot about your baby already," or "You have tried very hard to soothe him." Whenever possible, she uses the infant's behavior as an acknowledgement of parental competence ("Look how he calmed down to your voice") or guides the parents to acknowledge their own abilities ("What did you notice when you began to talk quietly to her?").

The FANA facilitator acknowledges parental concerns as legitmate; she does not attempt to normalize their experiences or provide reassurance. Rather, the facilitator attempts to guide parents through activities that will allow them to make observations that are relevant to their concerns, and to draw their own conclusions.

To encourage parental authority and "ownership" of the newborn, the facilitator is trained to speak consistently about the baby as belonging to the parents. She asks for permission each time she needs to interact with the infant: "May I pick up your baby?" "Would it be all right with you if I swaddle her?" This practice is in marked contrast with traditional hospital patient/staff roles, according to which parents must ask nurses and physicians for permission to see, hold, and take care of their baby.

Phase-specific skills

Phase I: Chart Review

Skills specific to this phase include the ability to: 1) read a medical chart and identify those aspects of the chart which may prove relevant to the here-and-now experiences of the family; 2) hold this knowledge of the family in mind; 3) use this knowledge sensitively to guide the experience; and 4) refrain from initiating a discussion with parents based on this knowledge.

Phase II: Parent Perception Interview

Skills specific to this phase include: 1) asking open-ended questions; 2) elaboration; 3) mirroring; and 4) reframing.

The facilitator asks five open-ended questions during Phase II: How are you feeling? How was your labor and delivery experience? What is your baby's name? Was she or he named after someone special? What have you noticed about your baby? As families respond to each question, the facilitator encourages parents to elaborate on their responses with prompts such as, "Tell me more about that," "What else have you noticed?", "Then what happened?"

The facilitator uses mirroring (repeating essentially what the parent just said) to acknowledge parental statements as important and to convey the facilitator's interest and involvement. In its simplest form, mirroring is a repetition of what the parent has just said, but as it is used by the facilitator it is an attempt to move rhythmically with the parents, much like Stern's (1986) description of parent/infant attunement. The facilitator uses tone of voice, body movement, and language to convey empathetically to the parents her recognition of the subjective experience that they are sharing with her. In response to a mother's description of a very difficult transition period during labor, for example, the facilitator might use facial expression and tone of voice: "Oh! It hurt that much!"

To help amplify and clarify their general thoughts, the facilitator reframes parents' comments by listening attentively and summarizing the essence of what has been said in clear, simple language. For example, to a mother who has given a lengthy description of an unexpectedly difficult labor, including her response to the use of pitocin, two internal monitors, and IV, and forceps, the facilitator might say: "So very much happened, so much was put into you, that you didn't expect."

The affective tone on this phase is essentially gentle and often quiet. The facilitator assumes a receptive, engaging stance which is meant to convey to the parents the message: "Tell me about yourselves. What is important to you right now?"

Phase III: NBAS Application

Obviously, proficiency in the Neonatal Behavior Assessment Scale is critical here. All FANA facilitators receive NBAS training, achieve reliability in the NBAS, and participate in quarterly NBAS re-reliability sessions. Not only do facilitators need skill in administering and scoring the NBAS, but they also need to be able to put these skills in the background as they perform their primary role of listening for the meaning that parents are giving to the behaviors they observe, and how this meaning matches or contradicts their initial perceptions of the infant.

Seven specific skills, adapted from Bromwich (1978) and from clinical experience, are important for the NBAS Application phase of the FANA: inviting, elaborating, modeling, encouraging, alerting, describing, inquiring and guiding. To invite, the facilitator actively solicits the parents' interest and directs their attention to a particular activity: "Would you like to take a look at what Johnny is doing right now?" To

elaborate, the facilitator adds detail or new information to recently presented parental observations: "Yes, Mary is sound asleep right now. There are several levels of sleep a baby can be in ..." To model, the facilitator tries out a particular NBAS activity on herself or the baby while explaining to the perent that this is what they will be doing shortly. For example, during the first habituation item where the parent is invited to pass a light across his sleeping baby's eyes, the facilitator presents the side of her closed hand and says, "Pretend these are Mary's eyes. Just pass the light across like this. Let's see what she does." The focus here is on the parents' engagement with their baby, rather than on their achievement of any level of precision with the activity.

To encourage parental participation, parents are asked what they have seen ("Let's see now ... what did Johnny just do?"). If the parent hesitates at all, the facilitator shares her observation. The tone is one of mutual sharing rather then question/answer/question; the facilitator shares her observation as a hypothesis for the parent to consider, rather than as a "fact." To alert parents and focus their attention, the facilitator may say, "Keep an eye open for what Mary does when you uncover her and put her on her back. She may fuss ..." To describe, the facilitator uses words to portray a process: "Your baby's toes flared out when you stroked the bottom of her foot."

To inquire, the facilitator asks if the parents have seen a particular behavior: "How does your baby suck?" "Have you seen him put his hand to his mouth?" To guide parents in the selected activities of the NBAS, the facilitator may actually take the parent's hand and guide it to optimize the infant's response. As she does this, she also conveys a sense of curiosity and adventure: "Let's see now, if you hold the ball right about here, and catch your baby's eye ..."

In addition to these specific skills, the facilitator makes use of her general process skills in this stage of the FANA: She asks permission if she needs to initate an activity, acknowledges parents' observations and maintains a steady, focused attention on the infant and parents.

During the NBAS Application, there is often a sense of heightened energy and typically an elevated affect in parents. Even when infants are presenting clear challenges and the parental task in the next weeks promises to be a demanding one (e.g., the 36-week gestational age preemie who does not habituate to light or sound and must be kept swaddled in order to reach a brief quiet alert state), parental attention is riveted to the baby. The facilitator works at maintaining this interest by using a somewhat faster pace than in the other phases while still respecting the comfort levels of infant and parent.

Phase IV: Integrative Summary

Skills for this phase include: summarizing, asking open-ended questions, anticipatory guidance, and completion. During the summary phase, the facilitator begins by summarizing briefly what the parents observed during the NBAS Application ("Let's think about what we just did together. We saw ..."). Next, she engages the parents in a series of open-ended questions designed to elicit parent feedback and give them an opportunity to affirm and/or recalibrate the perceptions of the baby that they brought to the FANA. She asks, "How did you feel about what we did together?" "What did you see that you expected to see?" "What did you see that surprised you?" When appropriate, the facilitator relates the parents' observations to their initial perceptions: "Remember in the beginning you mentioned that Timothy looked 'flimsy' to you? What do you think now that he has told you a bit more about himself?"

In this phase the facilitator helps the parents develop expectations and provides anticipatory guidance relevant to the issues that have emerged. The facilitator takes care to be sensitive to the parental affect in order to parallel hoped-for parent/infant interaction—i.e., doing for the parents what she hopes they will do for their baby. The FANA is completed as the facilitator congratulates the parents again and expresses pleasure at having had the opportunity to be together with them.

Most often, the affective tone during Phase IV is one of congeniality or congratulation. However, at times parents remain anxious or disappointed regarding their infant or themselves as parents. The affective tone may be one of frustration or sadness. The facilitator acknowledges these feelings, and gives parents support in their efforts to cope and live without resolution or to seek additional resources. In these situations, however, the facilitator either encourages the parents to return to the hospital post-discharge for a "come-back" FANA or offers to call them in a week or two. When indicated, the facilitator can make a referral to a range of hospital or community services for continuing support to the family after discharge.

Clinical applications of the FANA

How can a brief, one-time, hospital-based experience such as the FANA encourage a positive parental working model on the infant? We see the FANA as having three levels of clinical impact.

1. Support: For many well-functioning families, the FANA serves primarily as a supportive validation of themselves and their baby. The experience affirms the observations and positive efforts that these families are making and enhances the likelihood that the parents will be free to see and accept their "real" baby and both the pleasures and challenges that he or she will present.

2. Intervention: For families struggling with issues reactivated from the past or from present situational stresses, the FANA serves as a short-term intervention. The facilitator offers a structure in which the parents themselves can reassess their observations and create a new language for understanding the baby. During the NBAS Applications the infant himself, through his behavior, has an opportunity to challenge inappropriate parental expectations. During the Integrative Sum-

mary, the facilitator has the opportunity to make this challenge salient to the parents and to invite them to recalibrate their original perceptions.

While the FANA does not presume to address parents' early relationships or experiences that may encumber their current interactions with their newborn, the FANA can help parents cope with issues in the near past—specifically, painful labor and delivery experiences and prior perinatal loss. The whole experience is assisted and guided by the baby, whose behavior is generally compelling enough to break through the barrier of parents' painful near memories.

3) Assessment: The FANA can be used to assess parental competency in handling the newborn as well as parents' orientation to reality to the infant's needs. In the short postpartum hospital stay, the FANA can become an important adjunct to social work or psychiatric evaluation.

Conclusion

Family Administered Neonatal Activities (FANA) represent a promising merger of a clinical mental health model with an increasingly common practice in developmental pediatrics, i.e., the demonstration of newborn behavior to parents. The FANA offers families an opportunity to reflect on their perceptions of their infant and to check these against the infant's behavior, thus increasing the likelihood that the working model which guides them reflects the characteristics of the real baby.

In spontaneous comments and in written feedback, parents have been overwhelmingly positive about the FANA. Medical, nursing and social work staff at Evanston Hospital have come to rely on the FANA as a vital component of a family-centered approach to maternity care. Patient and staff satisfaction with the service, coupled with the hospital's desire to have a highly visible obstetrics service, resulted in an administrative decision to incorporate costs of the FANA into routine charges for obstetrics patients.

While the FANA has clearly demonstrated its clinical value in our setting, empirical examination of its effectiveness must also be undertaken. An investigation of the impact of the FANA on parental self-esteem, perception of the infant, and observational ability is planned. We also hope to adapt the FANA for families with infants who are born prematurely and for families with infants with congenital anomalies. Pilot work with infants at risk shows similar promise for the FANA as a helpful experience for all families during the newborn period.

References

Hanover: University Press of New England.

Brazelton, T.B. (1973) *The Neonatal Behavioral Assessment Scale.* Philadelphia: Lippincott.

Bromwich, R. (1978) *Working with parents and infants: An interactional approach.* Baltimore: University Park Press.

Cramer, B. & Stern, D. (1988) Evaluation of changes in mother-infant brief psychotherapy: A single case study. *Infant Mental Health Journal, 9*(1), 20-43.

Dunst, C. & Trivette, C. (In press) Helping, helpessness, and harm. In J. Witt, S. Elliott, & F. Greshman (Eds.), *Handbook of behavior therapy in education.* New York: Plenum Press.

Myers, B.J. (1982) Early intervention using Brazelton training with middle-class mothers and fathers of newborns. *Child Development, 53,* 462-471.

Nugent, J.K. (1985) *Using the NBAS with infants and their families.* New York: March of Dimes Birth Defects Foundation.

Nurcombe, B. Howell, D.C., Rauh, V.A., Tete, D.M., Ruoff, R. & Brennan, J. (1984) An intervention program for mothers of low-birthweight infants, preliminary results. *Journal of the American Academy of Child Psychiatry, 23*(3), 319-325.

Rauh, V.A., Achenbach, T., Nurcombe, B., Howell, C.T., & Teti, D.M. (1985) Overcoming the effects of neonatal adversity: Four-year results of an intervention for low-birthweight children. *Child Development, 59*(3), 544-553.

Shea, E. & Tronick, E.Z. (1988) The Maternal Self Report Inventory: A research and clinical instrument for assessing maternal self-esteem. In H.E. Fitzgerald, B. Lester & M.W. Yogman (Eds.), *Theory and Research in Behavioral Pediatrics, 4.* New York: Plenum.

Stern, D. (1985) *The interpersonal world of the infant.* New York: Basic Books.

Wildmayer, D.M. & Field, T.M. (1981) Effects of Brazelton demonstrations for mothers on the development of preterm infants. *Pediatrics, 67*(5), 711-714.

Woroby, J. & Belsky, J. (1982) Employing the Brazelton scale to influence mothering: An experimental comparison of three strategies. *Developmental Psychology, 18*(5), 736-743.

Wright, B. (1966) An approach to infant-parent psychotherapy. *Infant Mental Health Journal, 7*(4), 247-263.

Zeanah, C. & Anders, T. (1987) Subjectivity in parent-infant relationships: A discussion of internal working models. *Infant Mental Health Journal, 8*(3), 237-250.

Training Opportunities for Practitioners Working with Infants, Toddlers, and Their Families

The following is a list of new and ongoing initiatives submitted in response to an invitation to readers of *Zero to Three* to share information about training activities around the country for practitioners working with infants, toddlers and their families. Inclusion in this listing does not imply any review or endorsement by the National Center for Clinical Infant Programs.

Pre-service opportunities

Sponsoring institution: Albert Einstein College of Medicine of Yeshiva University, Rose F. Kennedy Center (Bronx, New York)

Training program: Additional 2 year grant to expand existing training program in early intervention. Multidisciplinary training provided to professionals and graduate students from New York City and Orange County. Offerings include an individualized practicum for limited number of graduate students in nursing, physical therapy, occupational therapy, psychology, speech-language pathology, social work and related fields (Oct. 1989-May, 1990). A 10-week training course offered during Spring, 1990, as well as a series of conferences and workshops for Orange County.

Contact:
Dr. Susan Vig, Rose F.
Kennedy Center
Albert Einstein College of Medicine
1410 Pelham Parkway South
Bronx, NY 10461,
tel. 212/430-2445.

Sponsoring institution: Boston University, Sargent College of Allied Health Professions, Department of Occupational Therapy

Training program: Master's degree program, with specialization in early intervention for occupational therapists.

Eligibility requirements: Certification as occupational therapist; bachelor's degree; one year professional experience.

Stipends: Partial tuition stipends available.

Contact:
Dr. Anne Henderson
Department of Occupational Therapy
Boston University - Sargent College of Allied Health Professions
Boston, MA 02215
tel. 617/353-2727

Sponsoring institution: Columbia University, Teachers College (New York City)

Training program: An M.A., Ed.M., Ph.D. or Ed.D. with a concentration, specialization or focus on infancy now available within a variety of departments. Opportunity for research and direct work with infants, toddlers and their parents at the transdisciplinary Center for Infants and Parents at Teachers College. Office of Continuing Education offers institutes and workshops for practitioners working in the field.

Stipends: Contact individuals listed below.

Contacts:
Dr. Annette Axtmann, 212/678-3013
Department of Curriculum and Teaching
Kay Alicyn Ferrell, 212/678-3862
Department of Special Education
Joseph Higgins, 212/678-3326
Department of Movement Science and Education
Lois Bloom, 212/678-3888
Department of Developmental and Educational Psychology for information about particular infant, toddler specializations.
For continuing education offerings, contact
P. Fey, 212/678-3718
Teachers College, Columbia University, New York, NY 10027.

Sponsoring institution: Cedars-Sinai Medical Center, Department of Psychiatry (Los Angeles)

Training program: Eleven-month internship for mental health and early childhood professionals and graduate students seeking advanced training in clinical child development. Training includes participation in the therapeutic nursery school, parent guidance groups, seminars, individual and group supervision, and clinical case conferences.

Eligibility: B.A. degree, preferably with prior experience with children, and a competence for psychological understanding.

Contact:
Dr. Susan Herz, Training Supervisor
Department of Psychiatry
8730 Alden Drive, E-105,
Los Angeles, CA 90048
tel. 213/855-4562

Sponsoring institution: Franciscan Children's Hospital & Rehabilitation Center, Department of Psychology (Boston)

Training program: Predoctoral internship training for psychologists (APA-approved). Base of training in an urban children's acute and rehabilitation hospital which is a training affiliate of Boston University School of Medicine. Specific training experiences focused on infants, toddlers and their families: community consultation to staff and parents of state-funded early intervention programs; choice of rotations in the assessment of young children; participation on interdisciplinary outpatient evaluation teams for infants, toddlers and families, etc.

Eligibility: Completion of all coursework and comprehensive examinations for the doctoral degree in clinical, counseling or school psychology.

Stipends: Stipends available at $10,000 per year.

Contact:
Dr. Mary Cerreto
Director of the Department of Psychology
Franciscan Children's Hospital &
Rehabilitation Center
30 Warren Street, Boston, MA 02135-3680
tel. 617/254-3800

Sponsoring institution: The Merrill-Palmer Institute — Wayne State University (Detroit)

Training program: Graduate Certificate Program in Infant Mental Health, an interdisciplinary program for graduate and post-graduate students in the fields of social work, education, psychology, and nursing. Coursework includes 12 credit hours of academic study and 10 credit hours of field placement. Program relies heavily on home visit model of intervention as developed by Selma Fraiberg and her colleagues. Clinical case supervision provided throughout the field placement and experiences with "at-risk" and "average" infants and parents included.

Eligibility: May be undertaken either (a) concurrently with a graduate degree in education, nursing, psychology or social work; or (b) by students with a master's or doctoral degree in one of these areas.

Contact:
Dr. Eli Saltz
The Merrill-Palmer Institute
Wayne State University, 71-A E. Ferry
Detroit, MI 48202
tel. 313/577-5244

Sponsoring institution: Minot State University, North Dakota Training program: Master of Science Degree in Special Education with concentrations in severe disabilities. Stresses service delivery formats applicable to rural populations including integration into local schools, day care centers, and other community facilities. Includes extensive clinical practica in direct service coordination and program facilitation utilizing interagency collaboration. Summer special topics seminars and workshops sponsored by the Infant/Toddler Program on a statewide basis.

Eligibility: Bachelor's degree in special education or an allied field.

Stipends: Dependent upon federal funding.

Contact:
Mr. Keith Gustafson, Director
Minot Infant Development Program
Minot State University
500 University Ave., W, Minot, ND 58701
tel. 701/857-3020

Sponsoring institution: Mental Retardation Institute—UAP in affiliation with New York Medical College at the Westchester County Medical Center

Training program: Interdisciplinary Training in Family-Focused Infant Intervention. Funded by Office of Special Education and Rehabilitative Services (OSERS). Didactic and clinical experiences offer disciplinary supervision and interdisciplinary training. Graduate credits toward MPH available. In-service education available to representatives

of early intervention programs.

Eligibility: Professionals and graduate students in special education, psychology, speech and language, social work, nursing, nutrition, occupational and physical therapy.

Stipends: A limited number of $1000 stipends and tuition support available to students enrolled in full 2 day a week program from September to May.

Contact:
Ellen Bodow, Project Coordinator
Cedarwood Hall, Rm. 425
Westchester County Medical Center
Valhalla, NY 10595
tel. 914/285-7388

Sponsoring institution: Northern Illinois University, Department of Educational Psychology, Counseling and Special Education Training program: Project LINKS (Linking Interagencies and New Knowledge Systems). A transdisciplinary, competency-based personnel training program in infant and toddler intervention, leading to a Master's Degree in Early Childhood Special Education. LINKS trainees complete 12 courses from a variety of disciplines. Also required are 450 hours of field-based experiences in a variety of selected early intervention programs. Innovative feature of Project LINKS is the delivery by each trainee of 20 hours of respite care to a family with a young child with special needs.

Eligibility: Admission to the graduate school, strong professional references, high academic achievement or potential, evidence of commitment to work with very young children with special needs and their families, and at least two years of successful experience in a related area.

Stipends: No federal stipends are available but qualified full-time applicants may apply for university assistantships.

Contact:
Dr. Carol Mardell-Czudnowski
Project LINKS
Department of Educational Psychology, Counseling, and Special Education
Northern Illinois University
DeKalb, IL 60115-2854
tel. 815/753-8424

Sponsoring insitution: The Ohio State University, College of Nursing

Training program: New Master's of Science clinical specialty track in parent-child nursing. Students have the opportunity for a subspecialty in childbearing nursing, high risk neonate nursing, or nursing of children.

Eligibility: Baccalaureate degree in nursing from an N.L.N. accrediated program, a 3.00 G.P.A., and satisfactory GRE scores.

Stipends: Some traineeships and graduate associate positions are available.

Contact:
Kitty Kisker, M.S., R.N., Director
Office of Student Affairs
The Ohio State University
College of Nursing
1585 Neil Avenue, Columbus, Ohio 43210
tel. 614/292-4041

FLORENCE SHARP

Sponsoring institution: The Oregon Health Sciences University, Portland University Affiliated Program (UAP)

Training program: The Parent and Babies Project. Provides training in working with multi-stress families and their high risk infants. Training provided at two levels. Level 1 is introductory, didactic presentation of 4 to 5 sessions for trainees in all of the 14 disciplines of the UAP. More intensive training occurs in a seminar format for long-term trainees who work directly with high biological risk infants. The group continues to meet in a group supervision process throughout the remainder of the training year. In 1989-90, training will be offered to community providers using an abbreviated curriculum.

Stipends: Limited stipends available at the UAP for trainees in pediatrics, dentistry, speech pathology, psychology, and nursing.

Contact:
Dr. Gloria Krahn
The Oregon Health Sciences University
University Affiliated Program
P.O. Box 574, Portland OR 97207
tel. 503/279-7634

Sponsoring institution: Purdue University, Department of Child Development and Family Studies (West Lafayette, Indiana)

Training program: Master's degree program for early childhood specialists to serve children under three and their families. Focus on functioning effectively as members of an interdisciplinary team. Program composed of a series of core courses and practicum placements in a variety of agency settings serving young children with disabilities.

Stipends: Limited number of graduate assistantships which include stipends or tuition waivers.

Contact:
Dr. Susan Kontos
Department of Child Development and Family Studies
Purdue University
West Lafayette, IN 47907
tel. 317/494-2942

Sponsoring institution: San Francisco State University, Department of Special Education

Training program: Master's degree program, Ph.D. program and an Early Childhood Special Education certificate program for professionals who work with young children and their families. Training accomplished through a combination of course work, field experiences, and an internship. Appropriate for a wide variety of professional disciplines.

Stipends: Applicants encouraged to apply for stipends.

Contact:
Dr. Marci Hanson
San Francisco State University State University
Department of Special Education
1600 Halloway Avenue
San Francisco, CA 94132
tel. 415/338-1630

Sponsoring institution: Temple University, School Psychology Program (Philadelphia)

Training program: Certification/Master's Degree in School Psychology with specialization in early childhood. Obtain competency in working with at-risk and handicapped children from 0-5 years of age. Three year program including practica and internship. Full and part-time students.

Stipends: Some stipend aid available.

Contact:
Dr. Carol Lidz, Program Coordinator
Temple University, School Psychology

Program, Ritter Annex
Philadelphia, PA, 19122
tel. 215/787-5745

Sponsoring institution: Tufts University, Eliot-Pearson Department of Child Study (Medford, Massachusetts)

Training program: Graduate programs in Applied Child Development leading to M.A., M.Ed., M.A.T., and Ph.D. degrees. Programs emphasize the integration of theory, research, and practice, offering students a strong background in child development for careers in research, teaching, administration, human services, and social policy. Students may construct their own programs and internships are available in a wide variety of academic and applied settings.

Stipends: Financial assistance available through research or teaching assistantships, tuition scholarships, and faculty research and training grants.

Contact:
Dr. Donald Wertlieb, Chairman
Eliot-Pearson Department of Child Study
Tufts University
Medford, Massachusetts 02155
tel. 617/381-3355

Sponsoring institution: University of Illinois at Urbana-Champaign

Training program: Two interdisciplinary programs in infancy. The Interdisciplinary Specialization in Infancy is a master's level program jointly sponsored by the Department of Special Education, the Department of Speech and Hearing Science, and the School of Social Work. Contains options for early childhood special educators who wish to specialize in infancy as well as for students from any discipline who wish to obtain core knowledge and skills. The Interdisciplinary Leadership Project in Infancy is a doctoral level program jointly sponsored by the Department of Special Education, the School of Social Work, and the Program in Clinical/Community Psychology. Both projects organized around a conceptual model that differentiates among disciplinary knowledge, within-discipline knowledge related to infancy, and cross-discipline knowledge related to infancy.

Stipends: A limited number of assistantships available for both the master's and the doctoral programs.

Contact:
Dr. Jeanette McCollum
Department of Special Education
1310 South Sixth Street
University of Illinois
Champaign, IL 61820
tel. 217/333-0260

Sponsoring institution: University of Maryland, Center for Infant Study

Training program: Training in infant psychiatry offered throughout the year. Individualized training programs arranged in accordance with the educational level and experience of trainees. They are offered on a 20 or 30 week basis (one day per week); as a two-day workshop; or as two semester weekly seminars.
Eligibility: Minimum eligibility requirements include master's degree and current employment in a community mental health center, private agency or other public social service organization.

Contact:
Dr. Taghi Modarressi, Director
Center for Infant Study
Howard Hall, Rm. 132
660 West Redwood Street
Baltimore, MD 21201
tel. 301/328-2485

Sponsoring institution: University of Minnesota-Duluth, Department of Allied Clinical Health

Training program: Provides opportunities for students pursuing a Bachelor's or Master's Degree in Communication Disorders to gain experience working with families through participation in INTERACT. INTERACT is a program of affirmation and education for families with infants, toddlers, and preschoolers with communication delays. Consists of 4-6 families meeting together for two hours in the evenings for six weeks. Each student intern paired with an ASHA certified speech pathology supervisor to work with one family.

Stipends: Graduate education in the communication disorders program supported with scholarship funds by the Edwin Eddy Foundation.

Contact:
LaVonne Levar
University of Minnesota-Duluth
13 Montague Hall, Duluth, MN 55812
tel. 218/726-6152

Sponsoring institution: The University of Texas Southwestern Medical Center at Dallas, University Affiliated Center for Developmentally Disabled Children

Training program: Traineeships available in administration, communication disorders, developmental and behavioral pediatrics, nursing, nutrition, occupational therapy, physical therapy, psychology, social work and special education. All trainees expected to participate in relevant research as part of their training experience.

Eligibility: Advanced graduate students with leadership potential

Stipends: May be available for long-term trainees (300 hours over 6 to 12 months).

Contact:
Dr. Linda Hurley, Director of Training
University Affiliated Center
200 Treadway Plaza, Dallas, TX 75235
tel. 214/904-2217

Sponsoring institution: Wheelock College Graduate School (Boston, Massachusetts)

Training program: Training in early intervention, child life and teaching young children with special needs. Components of family-focused training include courses and seminars, practica, family group supervision, a parent advisor, and a cross-disciplinary interactive seminar.

Eligibility: Bachelor's degree.

Stipends: Information available on request.

Contact: Karen Rehm
Early Intervention Program
Wheelock College Graduate School
200 The Riverway
Boston, MA 02215-4176
tel. 617/734-4176

NANCY P. ALEXANDER

Sponsoring institution: American Occupational Therapy Association

Training program: Three-day continuing education workshop in 20 states during 1990. Designed for occupational therapists working with young children with special needs, and their families. Will focus on providing practitioners with resources to develop and expand effective early intervention services in 3 essential areas: collaborating with families who have children with special needs; consulting on interdisciplinary teams of professionals and families; and working in an interagency system of health, education and social services. Faculty will include parents. A resource manual, being compiled to accompany the workshops, will be available for sale to individuals who cannot attend the workshops.

Eligibility: Occupational therapists who have had some pediatric background but are not necessarily working with children 0-3 years.

Contact:
Barbara Hanft
The American Occupational Therapy Association, Inc.,
1383 Piccard Drive, P.O. Box 1725
Rockville, MD 20850-4375
tel. 301/948-9626

Sponsoring institution: The Children's Health Council, Palo Alto, California

Training program: Annual 36-hour workshop entitled "Parentmaking: A Practical Workshop for Early Parenting Educators," (newborn to kindergarten age). Practical techniques and content with extensive hands-on experience and feedback to enable professionals to begin to teach parenting classes.

Eligibility: Trainees should have advanced degrees in education, counseling or nursing.

Contact:
Dr. Annye Rothenberg
Director Child Rearing Program
The Children's Health Council
700 Sand Hill Road, Palo Alto, CA 94304
tel. 415/326-5530

Sponsoring institution: Family Health Research, Education and Service Institute, Alma, Michigan

Training program: "Enabling 'Good Fit" in Infant-Parent Relationships" is offered as a 4-day, onsite, continuing education workshop covering psychosocial development of infants and toddlers; parent and family goal attainment through interaction with infants; individual characteristics of infants and parents which enable or limit such development and goal attainment; and applications for professional work with infants and families. Workshop serves as a foundation for additional follow-up modules on specific topics such as failure to thrive, psychosocial growth delay, foster care, teen parenting, etc.

Eligibility: Workshop is designed for educational, health care, and mental health professionals working with infants and their families. University credit may be available.

Contact:
Dr. Mark Rains
Center for the Study of Infants and their Families
503 N. State Street, Alma, MI 48801
tel. 517/463-2779

Sponsoring institution: Georgia State University, Parent-Infant Resource Center

Training program: "Interventions with High Risk Infants and their Parents," a series of monthly lunch meetings during 1989-90 for service providers in metropolitan Atlanta. The goal of the meetings is to provide service providers with the latest knowledge and with opportunities to network.

Contact:
Dr. Josephine V. Brown, Director
Parent-Infant Resource Center
Georgia State University
University Plaza, Atlanta, GA 30303
tel. 404/651-2928

Sponsoring institution: The Infant-Parent Institute, Champaign, Illinois

Training program: (1) Clinical Traineeship in Infant Mental Health: 1-year and 2-year traineeships include practicum, 10-month seminar series, and individual supervision. Possible to accomplish while employed or practicing elsewhere. (2) Brief Summer Course in Infant Mental Health, a 4-day intensive course open to any allied professional with clinical interest in the optimal development of infants and their families. 3) Seminar Series in Infant Mental Health, a 10-month bi-monthly small-group study of clinical issues in infant mental health using the case study method of instruction (September-May). 4) Winter Seminar on Loss and Separation in Infancy, a 2½ day intensive examination of the implications of object loss theory for child welfare and judicial practices (February).

Eligibility: For Clinical Traineeship, prior training and experience in pediatric medicine, nursing or psychology; clinical or developmental psychology; adult or child psychiatry; or related field. Determination of acceptance made after 3 interviews. For other offerings, strong interest in clinical application of theory and access to infants and families.

Stipends: Generally, none available.

Contact:
Michael Trout, Director
The Infant-Parent Institute, Inc.
328 North Neil Street, Champaign, IL 61820
tel. 217/352-4060

Sponsoring institution: The Maine Association for Infant Mental Health (an affiliate of the International Association for Infant Mental Health) and The Infant-Parent Institute, Inc., Champaign, IL

Training program: "The Awakening and Growth of the Human Infant: Studies in Infant Mental Health." A telecourse which includes 5 hours of videotape, a student handbook, an instructor guide, and 32 readings from the literature. Course has been approved for 3 University of Maine graduate credits and is designed for conventional classroom use or for transmission by public television networks or through closed-circuit, interactive TV channels.

Contact:
Anne Williams, BSN, M.Ed.
Infant Mental Health Specialist
11 Maple Street, Rockland, Maine 04841

Sponsoring institution: National Resource Center on Family Based Services, The University of Iowa School of Social Work

Training program: Center provides technical assistance, training, research, and information to human services agencies committed to family-based support, placement prevention and permanency planning programs. Offers 7 distinct family-based training programs, each designed to meet the specific needs of direct service workers, supervisors, and paraprofessionals in child welfare and community-based agencies. Programs available through both on-site workshops and 5-day residency programs at the University of Iowa.

Contact:
Dr. Wendy Deutelbaum
Director of Training
National Resource Center on Family Based Services
The University of Iowa School of Social Work
N240 Oakdale Hall, Oakdale IA 52319
tel. 319/335-4123

Sponsoring institutions: University of Washington, Seattle, WA

Training program: The Nursing Child Assessment Satellite Training Program (NCAST) has two upcoming training programs for licensed instructors to be held April 7-14 and October 20-26, 1990. Training will include assessment of infant interaction, feeding interaction, teaching interaction, and the home environment as well as intervention approaches.

Contact:
Georgina Sumner
NCAST, University of Washington
WJ-10, Seattle, WA 98195
tel. 206/543)8528.

Sponsoring institution: Philadelphia Parenting Associates, Philadelphia, PA

Training program: PPA offers training, education and consultation for practitioners and parents. Focuses on teaching practitioners how to integrate family support skills and techniques into their routine contacts with families; demonstrating the application of family support skills and techniques across disciplines and with various target populations; and preparing practitioners to use strategies, skills and techniques that promote parents' independent functioning. All programs designed in response to the needs of practitioners.

Contact:
Dr. Nancy Johns, Executive Director
Philadelphia Parenting Associates
127 Birch Avenue, Bala Cynwyd, PA 19004
tel. 215/668-8616

Sponsoring institution: Richardson Development Center, Inc., Richardson, TX

Training program: (1) On-site training available for case coordinators of family services. Trainees should have completed master's level work in education, social work, or psychology. No stipends available. Contact Liz Francis, FSCM. (2) For occupational therapists, field work II affiliations which include a caseload of small group center-based and individual home-based children. No stipends available. Contact Helen Prentice, OTR. (3) For speech pathologists, experience with feeding, tracheotomies, beginning communication, early language learning, and augmentative communication. Trainees should be post-graduate. No stipends available. Contact Kay Hopper, CCC, Richardson Development Center, P.O. Box 835066, Richardson, TX 75083-5066, tel. 214/490-0955.